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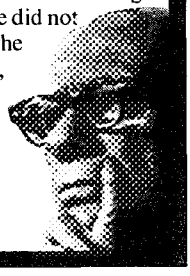

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A Revolutionary Answer to Medical Costs

by Charles Peters

Practically everyone now realizes that we need some form of national health insurance. The problem is how to control its cost. Our experience with those precursors of national health insurance, Medicare and Medicaid, suggests that extending their benefits to the entire population could produce national bankruptcy overnight.

Under the present system of health care, prices are set by the providers of health services—the doctors and hospitals—who also decide what services will be furnished and where they will be available.

This is not the way we have dealt with others in the business of protecting our lives: soldiers, sailors, policemen, firemen. We tell them where to serve. The policemen can't all patrol Park Avenue. The sailors can't all be based in San Francisco. Just because an army officer wants to be a cavalryman is not an adequate reason for letting him be one. We do not permit even the greatest general to charge us whatever he wants.

Is there any logical reason why medical salaries, specialties, and places of work should not be equally subject to public control? Isn't the assurance of good medical care as important to you as the assurance of adequate protection by the police or the military? Shouldn't doctors be trained in the areas of medicine where they are needed and stationed accordingly? Shouldn't their income be geared not to what they want, but to what the public can afford? If people don't like public control, they can choose not to become doctors, just as they can choose not to become midshipmen or cadets. If they are already doctors, they can choose not to participate in either the benefits or the restraints of a national health service. In fact, we may want a small group of physicians to remain in private practice to provide a competitive measuring rod for the public service.

A national health service should of course pay for all the costs of the training of its members, just as we pay for the training of our soldiers and sailors. Doctors who have already completed their training and elect to participate in the national service should be reimbursed for that part of the cost of their training that they actually paid.

This suggests an immediate reform that might be made. The public should take over the entire cost of physician training—we already pay a high percentage—and we should give every intern and resident a generous salary plus a free Jaguar. This would

Charles Peters is editor-in-chief of The Washington Monthly.

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deprive them of the last shred of justification for the self-pity that seems to possess all but the most decent doctors in later life, the self-pity that says because I was strapped to pay those tuition bills and because I was exploited as an intern and resident, I am now justified in robbing my patients blind. The doctor who thinks $75,000 a year is his divine right—indeed, a bare minimum from which he should advance to ever higher fiscal heights—is the spiritual father of the gross extravagance of our present health delivery system. And pending the day when we turn that system into one that the public controls, anything we can do to reduce his greed will at least delay our date with bankruptcy.

The British spend only four-and-a-half per cent of their gross national product for a system of free health care for everyone. We spend twice that for a system that ignores millions of people. A system with so much sheer waste—ridiculously expensive heart-lung machines and brain scanners in five or ten hospitals in a city where only one of each is needed. A system that squanders huge sums of money on sophisticated medical technology that only prolongs illness by delaying death for a few months.

Public control is the only way we can master these problems. Of course, it will have its disadvantages. The military that was brilliant at Midway was a parody of bureaucratic malfunction at Pearl Harbor. But our civilian health system is Pearl Harbor every day, with a fragmentation of responsibility so complete that one of the major problems in malpractice litigation is figuring out whether internist A, specialist B, or hospital C was responsible for the particular disaster at issue.

During World War II, I spent ten months in army hospitals with a broken back. I received consistently superb care. I was a buck private in the infantry. People of similar standing simply do not receive similar care from our civilian health system.

For some people, particularly those on the left, military analogies are not likely to be persuasive. For them, I offer the Foreign Service as a model. The doctor won't have to salute. He won't have to wear a uniform. We won't let him be stuck in Boisie for too long. But he will still be a servant of the public with a choice, just like the foreign service officer, of accepting assignment in the public interest or resigning.

Those who control whether we live or die must be under our control. We now control every group with a life-protecting function except doctors. It is time to end that exception. ■

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The Real Cause of Cancer

by Ronald J. Glasser

Today we know that above all else cancer is a cellular disease. What causes it to develop happens down inside individual cells, at the levels of molecules and membranes. Cancer is caused by injuries to minute subcellular structures, so small that they can barely be seen by our most powerful electron microscopes. We are just beginning to understand how these injuries occur and what the damaged structures are, and how, once injured, they can cause these cells to become malignant.

At a recent lecture at the University of Minnesota, a world expert on the experimental production of cancer struggled to define for his scholarly audience exactly what cancer is. He had great difficulty and began first with what it isn't: "It is not simply the rapid growth of cells; the bone-marrow cells that make all our blood cells grow very rapidly. We completely replace all of our red blood cells every 120 days, all our circulating white cells every six hours, and yet no one would say that this massive cellular turnover is cancerous."

He thought for a moment. "Indeed, cancers, even among themselves, show a wide range of growth rates, from the very slow-growing tumors which do not produce symptoms for years after their known onset, to those that reach lethal size within a few weeks. . . . Some of the most malignant and difficult-to-treat cancers are those that grow the slowest.

"Nor, for that matter," he went on, "are cancers restricted to just certain organs. They can and do arise from literally any kind of tissue cell. The opposite is also true—different kinds of malignancies can at times arise from the same exact tissue, each cancer, even though beginning from the same cell type, showing different biological properties. Some malignant cells can even appear totally identical to their still normal tissues of origin.

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Nor can you tell exactly how malignant a cancer might be from the form it takes. They can present themselves in any variety of cellular types ranging from a totally undifferentiated, primitive-looking group of cells to a well-organized tumor practically identical to the still normal cells surrounding it.

"In most cases," he added quickly, "cancerous cells maintain some relationship to their tissue of origin, so that sometimes, even though malignant, they possess the functional abilities of the parent cells. For example, thyroid cancers may still produce thyroid hormone, even though the cells making the hormone are obviously malignant. With all this variation we now know that it is not the speed with which a cell divides, how fast it grows, what it does, or what tissue it comes from that makes it cancerous, but its independence. It is the lack of control over the way a cell divides and grows that makes it malignant."

Carefully choosing his words, the expert finally gave what with all his preceding qualifications was at least a precise if somewhat limited definition: "Cancer is an autonomous growth of tissue, no more, no less."

In other words, the definition finally presented to the audience was simply that tissues become cancerous when the cells that make them up no longer respond to the external, or their own internal, subcellular controls, controls that restrain them and keep them in balance with all the other cells of the body. Instead of dividing and forming more of themselves in a restrained and totally organized way, or simply staying where they are and doing what they should do—making proteins, carrying hemoglobin, fighting infections, or transporting fats—the malignant cells take off on their own. Cells once docile and obedient begin to divide. Unrestrained, they begin to multiply, continually making more of themselves, until their sheer numbers squeeze out the still normal cells around them, and take over the organ in which they first began. Eventually each new cell, an exact replica of the first malignantly transformed cell, breaks out into the bloodstream or lymphatics, spreading to the other organs of the body, lodging in them, taking them over as well. If the malignant cells undergo transformation in a necessary organ

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like the brain or heart, the cancerous cells don't even leave the organ to kill the patient; they merely grow there until they interfere with some vital function like breathing or heartbeat, and the patient dies.

For other kinds of cancers the deaths are slower. A stomach filling up with malignant cells leads to nausea and vomiting and then starvation before the malignant stomach cells spreading to other organs cause death. Cancerous thyroid cells flooding into the kidneys crowd out normal kidney cells, causing the slow death of chronic renal failure and uremia. Nerves invaded by malignant breast cells produce excruciating pain long before the patient dies of disseminated tumor. Crippling pathological fractures caused by bones filling with metastatic cells may be the first sign of malignant lymphomas. Malignant cells invading lungs may cause asphyxia before they cause uncontrollable hemorrhage.

All the pain and all the suffering of cancer come from the continual invasion of the body's still normal tissues by its own malignant cells. Cancerous cells, unrestrained by their own or any of the body's normal control mechanisms, go where they please, take over the body's energy and fuels when they want, and in the process squeeze out or starve the body's still healthy cells, causing not only the patient's death but eventually their own as well.

Today we know that cells are divisible, that each cell is made up of subcellular ultramicroscopic structures. We also know that these structures interact chemically and physically with one another to keep a cell healthy, and that any injury to these structures, any interference with their communal microscopic interactions or control mechanisms, natural or man-made, is not only the cause of cancer, but basically the cause of all other illnesses as well.

It is not that any of this is really new. It is only our understanding of what does and does not cause disease that has changed. Cancers have been noted since antiquity. Hippocrates and Galen, describing them under different names, wrote of malignancies 2,000 years ago; Paracelsus gave classic descriptions of them well before the end of the 16th century. Livers turning malignant, lungs and stomachs eaten away, have always been a horrifying part of medicine; they have been with us from the beginning. Yet until a few years ago no one knew what they were, where they came from, how they kill us.

Much of the confusion about what was and was not cancer, about spontaneous cures and remissions, almost all of the myths concerning treatments and prognoses, came about because for centuries cancers were confused with other diseases. Looked at superficially, even today leprosy can easily be mistaken for the slowly eroding squamous-cell carcinomas of the face and hands, echinococcal cysts for hepatomas of the liver, tuberculosis for lung cancer. Primary and secondary conditions only added to the confusion. Kidney stones found mixed in with kidney cancers were invoked as the cause for renal failure, while the blood and pus of meningitis often obscured small tumors of the brain. For centuries putrefication, rather than underlying cancers, was conjured up as the cause of liver enlargement, while diseased arteries and veins were invoked for the tissue damage caused by infiltrating tumors or metastatic malignancies.

It was only when the microscope began to be used and precise microscopic evaluation of diseased organs and pathologic tissues became possible that the confusion about what was and what was not cancer finally began to be cleared up. There was no way under the microscope of making a mistake, no way any longer of confusing those wildly growing malignant cells with anything else. Physicians using their microscopes could definitively say this man died of cancer,

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Harry Swanson

that man of a bacterial infection. By the end of the 19th century pathologists were able, by looking at diseased tissues, to identify any number of malignancies by the type of cells that made them up—malignant melanomas, rhabdomyosarcomas, astrocytomas, adenocarcinomas, hepatomas. As their microscopic abilities improved, so did the number of diagnosed malignancies: osteogenic sarcomas, hypernephromas, oat-cell carcinomas, histocytosis. The list grew and grew.

But the names meant nothing. Patients died just as slowly and just as horribly with a correct diagnosis as those who had died misdiagnosed or with no diagnosis at all. The ability to recognize the various malignancies was only the beginning. The real question was not the what or even the how of cancer, but the why. Yet the ability of anatomists finally to be able to say that in this case the primary cause of death was malignant melanoma, in that adenocarcinoma, gave physicians what they had been looking for: a place to begin. By the 1890s physi-

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cians were able for the first time in history to know exactly who had cancer and who did not and precisely what cell type was involved. No one then could have realized that the search for what caused these malignancies, the search that would give meaning to the names they were just beginning to catalog, would take others down into the very heart of life itself, into chemistries almost too complicated to be dreamed of, into areas too small even to be seen.

The experimental study of cancer began in 1901, when the Japanese researchers K. Yamagiwa and K. Ichikawa finally proved that skin malignancies would result from the continuous application of coal-tar preparations to what previously had been normal skin. For a quarter of a century the mechanisms that caused the exposed cells to become malignant remained unknown. Up until the 1920s all that was known about cancer was what the Japanese had already proved: that there were carcinogenic compounds which, when continually applied to tissues, would cause the cells of these tissues to become malignant. Today we know that what produces malignancies are the same events that cause fetal toxicities and congenital defects—cellular damage.

The original discovery that upset the theory that cancer production results from nothing more than a constant exposure of normal cells to a carcinogenic agent was made by Peyton Rous in the early 1920s. Using the Japanese method for producing experimental cancers, he was painting rabbits' ears with coal-tar preparations, fully expecting to have to paint the same patch of skin for at least a year before any cancers became evident. Then, having to move his rabbits to another research area, he decided to renumber the animals by punching little holes in their ears so that they could still be identified even if there were two or three to a cage. To his surprise, cancers soon began to develop around the punch sites, months before any cancers were expected to be produced.

Rous' discovery that cancers would develop much earlier in normal skin exposed to a small amount of a known carcinogen if that skin was exposed to a second, in itself noncancer-causing, insult, even one as seemingly innocuous as a tiny cut, led to development of the important concept of cancer inducers and cancer promoters. This concept of inducers and promoters is now central to the understanding of how cancers are produced, not only explaining what have been some of the most confusing aspects of cancer production, but pointing the way to an understanding of not only why cancers take so long to develop but why malignancies are themselves so deadly.

The implications of this discovery were terrifying. The idea that small, virtually minuscule amounts of a known carcinogen—not the constant heavy exposure once thought necessary—could, if coupled or followed by some kind of irritant, produce cancers, had far-reaching implications. After the publication of Rous' and others' work on the production of malignancies, the real question facing cancer researchers was no longer whether chemicals could cause cancers, but exactly how long such exposures took, what exposure amounts were necessary, how carcinogens worked.

In 1940 I. Berenblum, one of the greatest cancer researchers of all time, beginning with Rous' observation, painstakingly set about to prove or disprove the crucial point of Rous' work, what was to become the crucial point of all cancer production—the precise importance of irritation. In short, he started out to discover what exactly the connection was between normal cells, carcinogens, and irritants. Could irritants alone cause cancer and how, in one tiny world of cellular differentiation, could minute, not massive exposures to carcinogens

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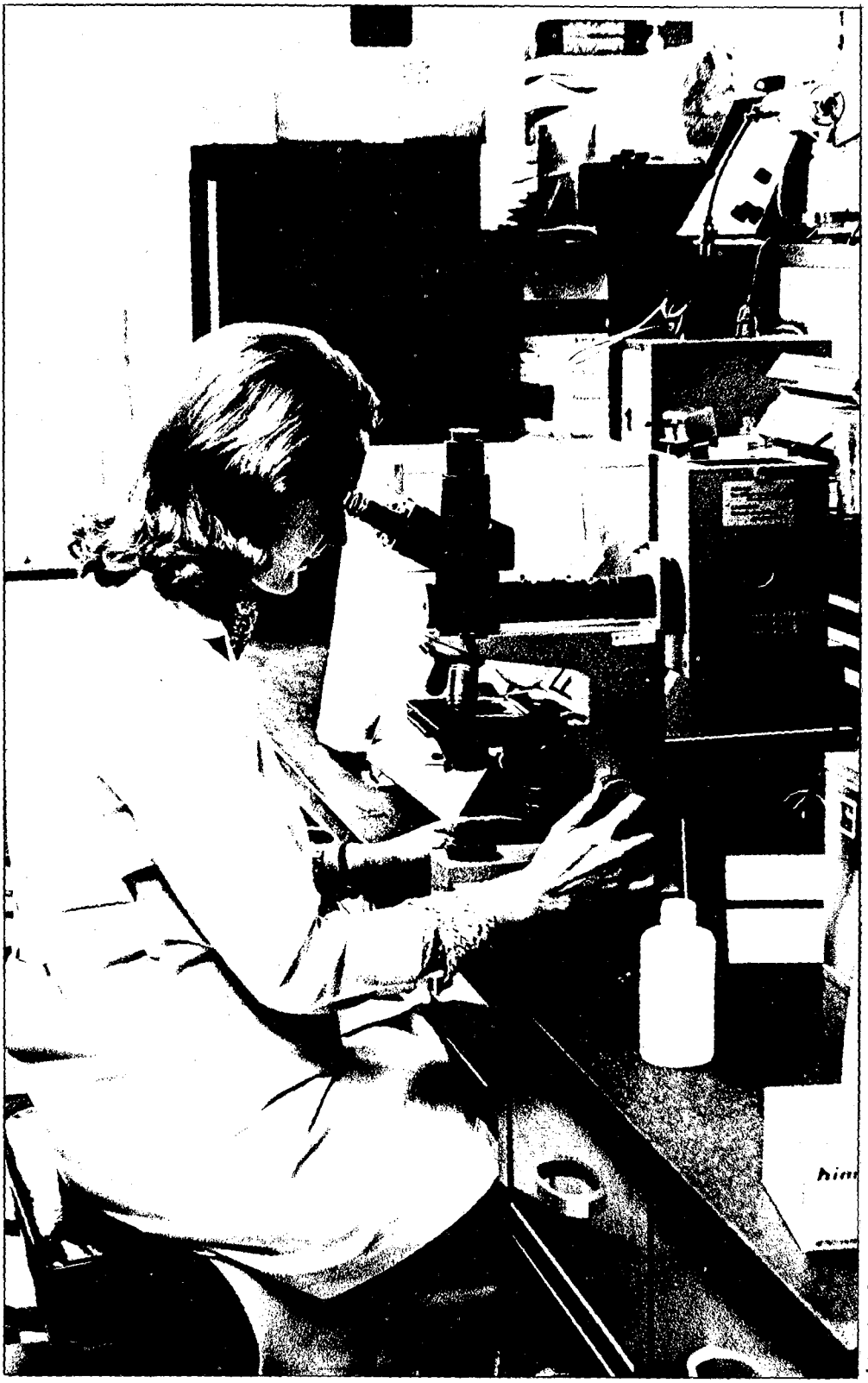

Victor Scruby

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cause normal cells to undergo malignant transformations?

He succeeded. Within a four-year period of virtually constant work he proved what industry today still refuses to acknowledge—that small, even infinitesimal exposure of normal cells to cancer-causing chemicals can cause malignant transformations.

Using benzopyrene, a very potent carcinogen distilled from coal tars, Berenblum began his experiments by rubbing the chemical into the skin of hundreds of animals. Dividing the animals into groups, he constantly increased the concentration of the benzopyrene. Unlike the crude, low-potency coal tar Rous had used, only a few applications of the concentrated benzopyrene were necessary to produce malignancies.

At very low concentrations of the chemical, no cancers developed in any of the exposed animals. It was only when the amount applied reached a certain high and seemingly critical level that the first cancers began to be produced. Once past that critical point, the number of animals developing skin cancer increased as the concentration of benzopyrene increased, until at very high concentrations of the carcinogen virtually every one of the animals developed skin malignancies.

But the truly important experiments were only now to begin. Berenblum realized he had really proved nothing with his increasing concentrations of benzopyrene that had not been known before. The real issue was whether even minute exposure to carcinogens changed the exposed cells internally so that despite looking and acting outwardly normal, they were really premalignant.

To find out, Berenblum went on to devise what has become one of the classic cancer experiments of modern times. It was an elegantly simple experiment, but it was to indicate the difference between life and death. Berenblum took the mice whose skin had been exposed to the low, apparently noncarcinogenic, doses of benzopyrene and rubbed the skin with croton oil. It had been known for years that croton oil applied to normal skin would cause irritation and redness but never cancer. Yet when he rubbed the oil into the supposedly still healthy skin, it suddenly turned cancerous and the malignancies produced were indistinguishable from those produced in animals exposed only to high concentrations of benzopyrene. He repeated his experiments with other mice and found the same thing. He could at will reproducibly initiate cancers in supposedly still perfectly healthy, though carcinogenic-exposed, skin by the addition of nothing more than an irritating solution.

The carcinogen absorbed by the cells, while not making them overtly malignant, had turned them instead into tiny time bombs, ready to go off at what appeared to be the slightest provocation. These pre-exposed cells, rather than healing themselves after exposure to irritating substances as any normal healthy cell would, instead became frankly malignant.

By this time, two new scientific words—initiator and promoter—had been coined. Carcinogens to which normal cells are exposed are called the initiators, and the irritant causing the malignant transformation, the promoter.

Berenblum made an even more ominous discovery, one that had to do with the time schemes involved. He soon found that no matter what he did, it always took exactly the same amount of time for a cancer to develop once the promoter was applied, no matter how long after the tissue had been exposed to the critical, though still outwardly noncancerous, level of the carcinogen. He rubbed the skin with a low-critical, though apparently noncancer-producing, concentration of a carcinogen and then waited days, weeks, months, or even years before applying the irri-

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tant; no matter how long he waited, no matter how long the interval between exposure to the initiator and exposure to the promoter, the cancer always developed in the same amount of time following application of the promoter.

This meant that once a cell is exposed to a low but critical level of a carcinogen, it becomes premalignant and stays that way, never reverting back to normal, always ready on exposure to some irritant—no matter how long into the future, no matter how distant in time from its original contact with the premalignant levels of carcinogen—to turn overtly malignant. A cell exposed to a carcinogen was apparently not only a time bomb, but a time bomb that continued to tick and would continue to tick until either it died a natural death or, exposed to an appropriate irritant, turned cancerous.

One thing became obvious at the very beginning of the studies of carcinogens and how they work. The changes that occur in exposed cells undergoing malignant transformations were irreversible; once transformed, the cells stayed that way. Once cancerous, they never reverted back to normal. The development over the last few decades of the ever more radical cancer operation, the increasingly brutal mutilation practiced by surgeons and agreed to by patients as well as their families—the legs removed with the hip joints still attached, the radical mastectomies, the total gastrectomies —all are grim evidence of this fact. For cells that won't revert back to normal, that once turned fanatic stay fanatic, there can be no half measures and in most cases no measures at all. Remove not only the cancer but the whole lung of cancer patients, and 95 per cent will still be dead within a year.

If just one malignant cell is left anywhere in the body, the cancer will recur. Malignant cells are relentless; leave just one cell and it is the same as not having removed any of the cancer at all. For some malignancies even the powerful anti-cancer drugs have proved ineffective.

It was plain to the first cancer researchers that cells which become malignant undergo some kind of profound and fundamental change. For these cells to defy treatments, never to revert back to normal, to continue to grow despite dosages of chemical poisons that could and did kill off the normal cells sitting right next to them, indicated that these cells are changed at their very core, and in an absolutely and profoundly fundamental way.

We now know that all carcinogenic substances, whatever they are, bind to intracellular particles, and the particles they bind to most strongly and affect most are the nucleoproteins contained in the nucleus of the cell—the DNA, the proteins that contain the genetic code. It is this DNA, holding within its own molecular arrangement the genetic code that tells the cell what it will be, what it will do, and how it will do it, that is affected most by carcinogens.

It is only within the last few decades that we have begun to understand how the different arrangements of the molecules that form the DNA act as genes. Astonishing as it is, the only difference in genes, the only difference in the structure of a nucleoprotein that tells one cell to turn into part of the liver and another into part of the brain, that keeps this cell in the lymph node making antibodies and that one in the stomach making hydrocholoric acid, that turns one fertilized egg into a fish and another into a child, is the sequences of the four simple carbon- and nitrogen-containing compounds that form the basic backbone of the DNA molecule: the bases adenine, guanine, cytosine, and thymine. In a chemical code a billion years older than life itself, the arrangement of these bases directs like a master computer the way the cell's proteins are made and how they are put together, what the cell wall will look like, what the cell does, what it

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produces, and how it divides.

We know today, and it makes absolute biological sense, that it is the nucleoproteins, with their bases seemingly so safely for billions of years locked away inside the nucleus of cells, that carcinogens injure. It has been proved through a decade of precise, laboriously controlled research that no matter what the carcinogens, chemical or physical, no matter how diverse or different they may seem to be on the surface—benzopyrene or aniline dyes, asbestos or X-ray—they all share that one same basic property. They all affect the cell's genetic material by getting into the cell, and once inside, work their way into the nucleus where they either bind to or simply destroy sections or parts of the cell's nucleic acids. We know that in large doses, carcinogens kill cells. They are all basically intracellular poisons. In smaller doses, because of their unique affinity for genetic material, they do not kill cells, they cause them to mutate, and it is this mutagenic nature of carcinogens that causes cancer.

If you take a hundred cells, grow them in tissue culture and expose the whole culture dish to X-rays or immerse it in what we know are carcinogenic compounds, you can, by increasing the dose of radiation or the concentration of carcinogenic material, kill every cell in the dish. But if you keep the doses of radiation or carcinogen to less than the amounts needed to kill all the cells, a few cells in each of the culture mediums will eventually turn malignant, assume unnatural shapes, and, beginning to divide at unnatural rates, quickly overgrow the whole culture dish. This is precisely what happens to the cells in your own body when they are exposed to a carcinogen and turn malignant.

There is nothing particularly mysterious about this. Carcinogens are toxic chemicals which are absorbed by or diffused into cells. Once inside, they work their way or are carried to the nucleus. There, in the submicroscopic world of cellular controls, one molecule of the carcinogen, or perhaps two or three at the most, physically couples with the bases or perhaps even the sugars of the nucleoproteins, and like a monkey wrench jamming the control gears of a complicated factory, destroys or interferes with two billion years of finely tuned evolution.

If there is any one overriding concern that haunts physicians today, one great fear that drives cancer researchers and keeps them working and publishing their findings in the face of powerful industrial and at times political opposition, not to mention personal and professional abuse, it is that a low-grade but potent cancer-causing substance may be introduced into the general environment unknowingly or uncaringly, to be consumed by vast numbers of people, dooming them before they even know about the inevitable and untreatable malignancies.

These researchers know that minute exposures of cells to carcinogenic compounds can lead to cancer, and that because of the uniqueness of malignant diseases, the long time lags between exposure and the development of overt cancers—in humans as long as 25 to 30 years—a carcinogen, if distributed among the general population, might well doom hundreds of thousands, perhaps even millions of people before the harmful effects of the chemical became obvious enough to stop any further distribution. Whole generations could be wasted before we would even know we were in danger. The dead would be our first warning, and the dying would continue for decades, until those last to be exposed would themselves finally be buried.

The grim fact is that this has already happened. The researchers' greatest fear has already come true, and examples abound.

■ Beginning in 1941, in the name

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of patriotism, with the tacit agreement of the federal government and the wholehearted cooperation of the American Red Cross, almost every healthy young adult male between the ages of 18 and 26 in the entire U.S. population was systematically if unknowingly exposed to a low-grade but potent carcinogenic. From Guadalcanal on, the exposure was massive and continual. The USO, religious groups, friends and relatives, all made sure their young men, no matter where they were, received cartons of cigarettes. What from World War I had grown into an individual habit became with World War II a national institution.

It is not far-fetched today to say that the cigarettes delivered month after month to the Marines on Guam and Saipan, the airmen flying out of Tinian and Iceland, the Third Army pushing up through the Rhine Valley, the 101st and 82nd Airborne in Holland and Belgium, would eventually prove as deadly to those young men as any German bullet or Japanese rocket. Those cigarettes would eventually kill as many of them as any grenade or mine.

■ In 1956 an international conference of scientists in Rome declared Red Dye Number 2 to be a suspected carcinogen. Under increasing challenge in the United States as a cancer-causing agent, this same dye was recently cleared by the Food and Drug Administration for unlimited use in foodstuffs. But so much pressure was brought to bear, so much opposition generated by consumer groups, that the agency subsequently reversed itself and late in 1975 banned further use of the chemical in new products, but allowed the continued sale of any products that contained the dye before the ban. It is still there in the food we are eating.

■ It was the sudden appearance of a rare type of cancer that alerted health officials to the dangers of PVC, polyvinyl chloride. Like aflatoxin, PVC injures the liver. However, unlike aflatoxin, it is not ingested and absorbed into the bloodstream through the stomach, but through the skin or mucous membranes. Nor does it, like aflatoxin, injure the liver cells themselves, but the cells of the small blood vessels that line the liver. Polyvinyl chloride causes those small vessel cells to turn malignant, producing a particularly deadly form of cancer called angiosarcoma.

■ In the late fifties it was discovered that workers involved in the production of asbestos-cement fireproofing materials and insulation had rates of cancer ten times that of workers in other industries. Inhaled and ingested asbestos particles were found to be carcinogenic, causing lung cancer as well as a rare type of malignancy—mesotheliomas of the chest wall. The discovery of the carcinogenic nature of asbestos fibers, like the discovery of the malignant properties of polyvinyl chloride, was too late for the workers already dead; it was even too late for those who were not dead at the time of the discovery but had already been sufficiently exposed to be in risk of dying. But if proper protection is used, it is not too late for the children and adolescents who will someday work in those factories or even those adults who are starting today.

There is, among all this bad news, one vital, hopeful sign in cancer prevention.

Scientists have given us an important clue—a definitive diagnostic test—to determine what is a carcinogenic chemical and what is not. Indeed, the development of this test is potentially one of the most important environmental advances in modern-day preventive medicine, and could in time be to cancer prevention what the development of vaccines was to infectious diseases.

In an example of individual persistence combined with scientific ingenuity and human concern, one man, Dr. Bruce Ames of the University of

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California at Berkeley, did what everyone said could not be done: he developed a test to prove if a chemical could cause cancer. If, as he realized along with other scientists, the majority of human cancers are caused directly or indirectly by substances in the environment, what was needed was a quick, reliable, and inexpensive way of identifying the chemicals involved.

In Ames' own words: "About ten years ago I got fed up reading the long list of chemicals on potato chip labels and wondering if they were safe. . . . No one was testing anything to see if there was a mutagen. . . . At any time something could creep into our diet that would significantly alter our genes and we would never know it. So I started manipulating bacteria to see if I could sensitize them to detecting chemicals that can cause mutations."

It took Ames a decade to develop his test. Since carcinogens are mutagens, he reasoned that if a chemical caused a cell to mutate, it would in all probability cause other cells to become malignant. All he needed was a way to look for cellular mutations, and he found one.

The test Ames finally devised is very simple. He developed a strain of bacteria that cannot grow in a certain type of nutrient-deficient broth, one without an amino acid called histidine, but can, with a slight change in its DNA—a mutation—begin to use the broth to grow.

The use of bacteria was just a convenient way of studying the effects of chemicals on genetic material. Since all DNA, whether it comes from a microorganism, a mouse or a man, is basically the same, a chemical that damaged the DNA in the nucleus of a bacterium would in all probability damage the DNA in man. Bacteria are single-cell organisms. Like all living things, the nucleoprotein in their nucleus is chemically similar to the DNA in all other living things, including the DNA in our own cells.

The Ames test begins with the addition of small nontoxic amounts of the chemical under investigation to the special histidine-deficient broth. If the chemical gets into the bacterial cell, into the nucleus, and affects the bacteria's nucleoproteins, it will cause mutations, and with the mutations some of the bacteria will begin to grow.

The Ames test system consists of a small covered laboratory dish filled with broth-growth medium seeded with millions of bacteria called *Salmonella typhimurium*. Ames has modified his bacterial strain genetically by selective breeding so that they cannot grow without histidine in the broth medium. The chemical to be tested is spotted on the broth, and the dish incubated at 37 degrees centigrade. At the end of two days the number of bacterial colonies that grow in the vicinity of the spots of the chemical are counted. The test is that simple and that definitive.

Each colony of growing bacteria represents a salmonella that has mutated, one that the test chemical has entered, changing its DNA, so that under new control the bacterial cell can now manufacture its own histidine, and unlike its unmutated neighbor not exposed to the spots of chemical, grow and divide in the histidine-different medium. The more colonies growing in the dish, the more active the chemical in causing mutation.

Ames continued to add variations to his test to make the system more applicable to humans. He peeled off the cell walls around the bacteria that ordinarily keep out large molecules. This has made the test sensitive to chemicals that might otherwise not be able to get into the bacteria. He has also incorporated liver enzymes into the culture medium, which can convert certain inactive test chemicals into active mutagens, mimicking what happens to chemicals entering the human body; and he has found carcinogens forming from chemicals that by

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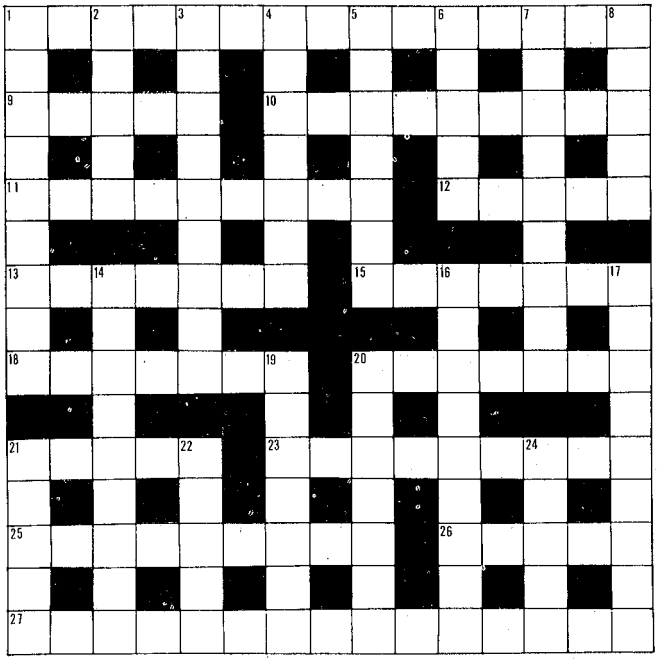
the political puzzle

by John Barclay



ACROSS

1. Battle deed sieve arranged for 1976, like 1960. (9,6)
9. Escape by taking back the last part of schedule. (5)
10. A trial log set up for Florida resident. (9)
11. Put back in harvest spot? (9)
12. Study aids for some races. (5)
13. For a pro, a point; a pol, a term; others, a sentence. (7)
15. Deny a little Congressman mixed up in a joint. (7)
18. CPA's sit in disarray, out of control. (7)
20. Imagine crazy department with mat out. (7)
21. Complaints about steaks? (5)
23. Beginner makes three eyes. Not art! (9)
25. An arm redone will work out for now. (6,3)
26. Kind o' name called first in Ireland. (5)
27. What Carter and Ford seek turns out to be not invented deep. (11,4)

DOWN

1. They follow the theme disturbing this store. (9)
2. Girl found in what you'd call a uranium pit. (5)
3. Look at promontory discloses bias? (9)
4. Asserting by putting it in insects going up. (7)
5. Addle it some way to get things opened up. (7)
6. It's not weighty but the ball in the middle. (5)
7. Allow it our haze strangely. (9)
8. Tricky snare is what he deserves. (5)
14. Paper quantity finished is changed again. (9)
16. We all pay attention to messy deerprints. (9)
17. Restore nude crane for lasting power. (9)
19. Mine car converted for war. (7)
20. Soldier has four in to talk on and on. (7)
21. A deer is a Roman baby no-no. (5)
22. Turn French parks upside down for a piece of paper. (5)
24. Time to put a short emperor into. (5)

The numbers indicate the number of letters and words, e.g., (2, 3) means a two-letter word followed by a three-letter word. Groups of letters, e.g., USA, are treated as one word. Answers to last month's puzzle are on page 59.

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themselves, out in the environment and not yet ingested, might not be dangerous.

As a member of the National Institute of Environmental Health Sciences said recently: "This test system has proved its capability of identifying potentially dangerous chemicals in a quick and efficient way."

Benzopyrene has proved, as would be expected, to be mutagenic in the Ames bacterial system, as have aniline dyes and radiation. What happens to bacteria exposed to carcinogens is what happens to human cells. A gene in the cell's nucleus is injured. Like the mutated salmonella that can then grow in histidine-deficient broth, the genetically damaged human cell, its controls changed, short-circuited, or suppressed, takes off in a new direction.

That is really what cancer is. For all the suffering it causes, it is nothing more than a loss of intracellular control, a genetic mutation induced by injury. We tend to think of mutations in terms of the whole person, the albino or the dwarf, but the basis of all overt observable mutations is cellular.

If a mutation—damage to the nuclear DNA—occurs to embryonic cells during fetal development, the results show up as fetal deaths or congenital defects. If the mutation occurs in a fully matured cell, one that will not give rise to any other cell types, only that cell's nucleoprotein will be altered. But the change is still as permanent as any mutation in a fetal cell and will be passed on to all the cells that spring from it. Once DNA is changed, once the genetic code is altered, that change is permanent, forever.

We have now begun to realize that the problem of environmentally induced cancer is that the changes that are caused by the carcinogen are all internal, occurring in the cells' DNA; the surface of these malignant cells stays the same as normal cells'. There are no new markers—no biologically active "antigens"—on their surface to be read as foreign by the body's defense system. Antigenetically like any other cells, ignored by the body's defense system, these malignant cells grow unrestricted, uncontrolled by any of our body's defense or reparative systems. That is why there is virtually no hope of survival for those who have smoking-induced lung cancer or asbestos-induced mesotheliomas.

Ames has given us a test, a first step in making sure we are not exposed to carcinogenic substances. Food samples are tested all the time for bacterial contamination; no one thinks anything of it. Indeed, there is a great governmental bureaucracy devoted solely to testing for bacterial contamination not only in foodstuffs but water supplies. State health departments, city and municipal health officials, the Center for Disease Control in Atlanta, all are devoted to the control and prevention of communicable diseases. Bacterial or virally contaminated products when found are removed from the market or destroyed. Infected municipal water supplies are closed down. Companies that distribute salmonella- or botulism-contaminated products are allowed by a suspicious public to go bankrupt or lose substantial parts of their market, and everyone feels the loss is justified.

At a recent New York Academy of Science workshop, Dr. Fred de Serres said the Ames test "would help industry establish priorities on which chemicals to develop, allowing industry to screen chemicals very early in development instead of investing hundreds of thousands of dollars in a substance only to find out later it causes cancer."

With the use of the Ames test, in a matter of two days at a cost of approximately $600, rather than the hundreds of thousands of dollars, the two to three years, and the huge facilities necessary to do the appropri-

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ate animal studies, a potentially dangerous chemical can now be quickly screened for its ability to cause mutation, to damage the genetic material of cells.

There are industries today that resist the idea that their products may cause disease, just as in a former day the idea that illness could be caused by contaminated water was resisted. Recently Dr. Ames felt it necessary to write an open letter to Dr. John Menkart of the Clairol Corporation in response to a letter Menkart had sent out under Clairol's letterhead challenging not only Ames' conclusions about the carcinogenicity of hair-spray products but the validity of the test itself.

"I believe Menkart's letter is extremely misleading and irresponsible," Ames wrote. "We have developed a rapid and sensitive test using bacteria and animal tissue, for identifying mutagens, chemicals that damage the genetic material. Data obtained with this test have shown that over 80 per cent out of 140 carcinogens tested show mutagenic activity while very few chemicals in general [100 noncarcinogens] are mutagenic. From the data we concluded that chemicals active in this test have a high probability of proving to be carcinogens. We find that 150 out of 169 oxidative-type hair dyes tested, most of the semi-permanent type dyes tested, nine of the components of hair dyes, and several oxidation products of hair dye ingredients are mutagenic. Hair dye components can be absorbed apparently through the human scalp."

Others, too, have been concerned about the dangers of hair dyes but they, for whatever reasons, kept the dangers secret. *The FDA Consumer* had stated even before Ames' letter that hair dyes "were specially exempted from the Federal Food, Drug and Cosmetic Act of 1938 by Congress after Industry persuasively argued that the dyes could not meet safety standards of the act but should nonetheless be sold to meet popular demands."

The fact is that the hair-dye industry had already guessed wrong once about the dangers of their chemicals. 2, 4-Diaminotoluene, which was used in hair dyes for many years, was first shown to be a carcinogen in animal studies in 1955 and again in 1969. Yet hair dyes containing this chemical were still on the market as late as 1971.

What Ames felt compelled to write about was not rates of bacterial mutation, or the reproducibility of his results, but human cancer and birth defects. Once a quiet, cloistered academician, he has had to do what concerned physicians and scientists making discoveries opposed by vested interests have always had to do. Like Snow more than a hundred years before him, and Paracelsus and Pare centuries before Snow, Ames has had to make a public fight for the public's health. And people are finally listening.

With a continually growing awareness among the public of the environmental nature of cancer, more and more companies are overcoming an initial reluctance to use Ames' methods and are beginning to apply his test to the evaluation of new products while those products are still in their early stages of development. No company wants to have someone else label its products as carcinogenic. Yet, there is still reluctance in many industries to test already existing products.

What must be done is simple. The Ames test and others like it must be made as mandatory and routine a health procedure as is the testing of our food products for bacterial contaminants and our water supplies for purity.

Cancers are no more inevitable than is cholera or smallpox. By knowing what causes malignant transformation we can stop cancer as surely as knowing the cause of polio stopped the production of iron lungs. ■

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Tidbits and Outrages

Selfless Idealism

Stuart Auerbach of *The Washington Post* has come up with more evidence of the selfless idealism of our doctors and dentists:

"Medical and dental students have told Congress they strongly object to a bill that would force them to pay back some of the federal funds given their schools to pay for their education.

"Although doctors and dentists are among the nation's highest paid professionals—doctors earn an average income after expenses of $52,000 a year, dentists net $37,500—and are the only professions to receive direct federal subsidies for their education, the students said they could not afford the added $8,000 debt the new law would entail.

"A third-year dental student at the University of California at Los Angeles, Jeffrey White, promised that 'any sum of money which I as a dentist must pay the federal (government) after graduation will ultimately be paid by my patients.'

"Another dental student, Gerald Shinkawa of San Francisco, complained that he would have 'the problem' of passing 'the costs to the patients' and then justifying them to dental insurance companies.

" 'There is no room in my economy,' he continued, 'for the demands this bill is trying to force upon me.' " (From the September 1973 issue)

Medical Care

For those who missed that masterpiece of black comedy, Paddy Chayevsky's *Hospital* with George C. Scott, here is another version from Michael Kiernan of the *Washington Star*:

"Stanford Hardy, a District policeman, drove himself to George Washington University Hospital 10 days ago to undergo an operation on his knee. Today, Hardy will be buried with honors normally reserved for officers killed in the line of duty.

"What transpired between Hardy's entering the hospital last week and his burial today 'is one of the most tragic and confusing series of events I've ever heard a police family go through,' Police Chief Maurice Cullinane said yesterday.

"For Hardy's wife, Ellen, and his four young children, the nightmare began a week ago Thursday when a doctor informed Mrs. Hardy that while her husband was on the operating table his heart had stopped beating, but had started up again. Hardy, 31, of 2744 75th Ave., Landover, had walked into the hospital a day earlier for an operation on his knee, which had been troubling him since August 1973 when he injured himself in a minor scooter accident.

"After the operation, during which Hardy was under general anesthesia, 'the doctor called and told me that my husband's heart had stopped beating, but that it had started up again and the doctor said they were optimistic that he would be all right,' Mrs. Hardy said yesterday. The next day, Friday, Mrs. Hardy visited her husband and found him 'all taped up to a respirator. . . . It was the only thing keeping him alive. He appeared dead to me.' That day and Saturday, he was registering 'brain activity,' according to a hospital spokeswoman.

"On Sunday, shortly past noon, Hardy was officially pronounced dead.

"That afternoon, Mrs. Hardy said, she 'signed a piece of paper allowing them to remove my husband's kidney. . . I never knew they were going to remove his eyes,' she said. The hospital spokeswoman said yesterday that Mrs. Hardy had signed a release form authorizing the use of the corneas of Hardy's eyes as well as his kidneys. 'Perhaps Mrs. Hardy did not understand what a corneal transplant entails,' the

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Some Golden Oldies and Our Favorite Medical Scandal

This month the first two pages of this section consist of classic tales of the medical profession culled from past issues. The best one we've heard lately concerns a Maryland dentist, Dr. Early Lee Trice, who claimed reimbursement from Medicaid for having extracted 38 teeth from one patient. The human jaw contains 32 teeth.

Doctor's Difficulties

All of us who spend every dollar we make can sympathize with the plight of the 35-year-old Florida physician described in the March 1974 issue of *Medical Economics*. He is earning $75,000 a year and spending the $41,000 that's left after taxes and premium payments on his $250,000 life insurance. The doctor has to make do with a home with two fireplaces, eight TV sets, and a swimming pool. He also bought a $27,000 boat and spends $1,000 a year on golf and $100 a month for heating his pool. In addition to the problems that arise from having nothing left over, the doctor has to face a shortage of garage space: he owns two late model Lincoln Continentals and one 1974 Pontiac Firebird.

It is reassuring to know, however, that in the midst of problems such as these, dedicated physicians squeeze out a bit of their valuable time to protect the public. Thus a recent AMA panel warned against quackery among America's acupuncturists. The doctors solemnly intoned: "In China, acupuncture is not practiced for money. In our Western society, it should not become a technique for exploitation of the public." What the acupuncturists may not realize at first is that the doctors are trying to protect them from all those problems that come with having nothing left after the $41,000 is gone. (From the September 1974 issue)

spokeswoman said. (Hardy's kidneys have been transplanted, the hospital spokeswoman said, and the corneas have been given to an eye bank.)

"On Monday, Mrs. Hardy said, she 'waited and waited and waited' for word about when her husband's body would be ready for removal from the hospital. Late Monday afternoon, Mrs. Hardy said, she called the hospital. 'A doctor's assistant was very apologetic to me and said the body had been transferred to the city morgue for an autopsy.' So Mrs. Hardy called the police, who checked with the D. C. Medical Examiner's Office, which reported that it did not have the body.

"At that point, Mrs. Hardy said, she called several friends and proceeded to George Washington University Hospital to find out where her husband's body was. 'Late that night we were told that the body was still at the hospital and that it would be transferred to the coroner's office the next day,' Mrs. Hardy said.

"On Tuesday, while the autopsy was being performed, Mrs. Hardy decided she wanted her husband buried in his police uniform. But police officials told her that this was against a policy allowing only an officer killed in the line of duty to be buried in full dress uniform. 'It's a way of giving special tribute to a man or woman killed while on duty,' Cullinane said. The police chief said he decided yesterday morning, however, to make a special exception in Hardy's case 'because the Hardy family has gone through so much anxiety the past few days.' Cullinane's decision came shortly before a local activist, Goldie Johnson, held a press conference attacking Cullinane for 'this insensitive policy.'

"Meanwhile, the District's chief medical examiner, Dr. James Luke, said yesterday his autopsy of Hardy found nothing to explain why Hardy's heart stopped. 'The heart was found to be completely normal,' Luke said. Luke attributed the cause of death to 'cardiac arrest' (stoppage of the heart) which took place during surgery.

"The hospital spokeswoman said the hospital staff would 'extensively review' circumstances surrounding the death. 'It's regrettable that things did not go more smoothly for Mrs. Hardy, who apparently went through considerable anxiety since her husband entered the hospital,' the spokeswoman said." (From the April 1975 issue)

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Ts & Os

You Can't Tell a Book

On the cover of Ward Just's new novel, *Nicholson*, there is this picture of the book's hero:

Inside on pages 106-8, he is described as follows:

"He looked at his face in the bathroom mirror.... Without the wrinkles and the crow's feet around the eyes, the broken blood vessels and the battered look of the nose, this face would be the face of a teenager. Well, the eyes were not bright.... It was the face of a forty-year-old man, anyone who looked at him could guess his age without hesitation. He concluded, pleased, that it was a face difficult to misread."

The Crusade for Truth Continues

In the August 24, 1976, issue of *The Washington Post*, there was an article headlined "The Plains Farmer Stages a March Across Movieland" that described Jimmy Carter's first Beverly Hills party. Among those listed as present were Sidney Korshak, identified by the *Post* as "a prominent Los Angeles labor attorney with ties to the Teamsters union and the entertainment industry" and as a "supporter of the Democratic National Committee."

If you also read *The New York Times*, you would know that Korshak had been nailed in a series of articles by Seymour Hersh as the top link between the mob, the Teamsters, and Hollywood. Because the *Post* is still getting revenge for the *Times*' failure to credit the *Post*'s scoops on Watergate, the *Post*'s readers were denied important information about the kind of person Jimmy Carter was socializing with.

Doing Well by Doing Good

In one of our golden oldies in the preceding pages we discuss a doctor who was making $75,000 a year in 1974. New York now has one making ten times as much from Medicaid payments alone. And CBS's "60 Minutes" recently featured Dr. Clarence Edwards of Washington, D.C. and Snowmass, Colorado, who makes $250,000 from his regular practice and $309,000 from Medicaid. By seeing his 12,000 patients at the rate of 100 per day, he is able to fly his private plane off to six to eight weeks of vacation per year.

The President Is a Perjurer

John Dean's new book, we hear, will confirm Marjorie Boyd's two articles in this magazine (April 1973, October 1975) to the effect that Gerald Ford worked with the Nixon White House to block congressional investigation of Watergate before the 1972 election and that Ford was guilty of perjury when he denied this collaboration during his confirmation hearing. In other words, Ford was part of the cover-up, and he later lied about his role in it. The White House tapes clearly showed this, but it got lost in the shuffle; now, with Dean's book, perhaps Watergate will become a campaign issue for the first time.

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What People Like You and Me Are Doing to Get Better Health Care

by David Hapgood

It's that impatient condescension. The doctor will listen to us briefly, even though we speak barbarous English instead of his medical Esperanto, but his entire manner makes it abundantly clear that he can barely wait for the dialogue to be over. He'll work his miracles of modern science, if only we'll hurry up, and shut up, and pay the bill. And, above all, don't waste his time with questions. He is the expert in full bloom.

This lordly image of the physician, so different from the kindly family doctor of the half-forgotten myth, is at the center of the growing struggle for more public control over the vast, expensive, and admittedly inefficient health industry. Much of the time it seems that nothing is happening: a new national health insurance plan is announced; it vanishes down the drain like its predecessors; prices keep going up. Yet, down below the headlines, a surprising amount of change can be seen. The public is getting at least a fingertip on the levers of power, and the industry itself is responding in various ways to the demands on it. Indispensable to this process of change is a more informed, more skeptical, more healthy view of this most mysterious of the services we get from the experts.

We are beginning to abandon the exaggerated expectation—foisted on us, mainly by ourselves, during the years of optimism—that the health industry can solve all our problems. The miracles of modern medicine are of limited application. In *Who Shall Live?* health economist Victor R. Fuchs quotes a physician writing in *Medical Economics*:

"Fully 80 per cent of illness is functional, and can be effectively treated by any talented healer who displays warmth, interest, and compassion regardless of whether he has finished grammar school. Another ten per cent of illness is wholly incurable. That leaves only ten per cent in which scientific medicine—at considerable cost—has any value at all."

That statement is less than com-

David Hapgood is a contributing editor of The Washington Monthly. *This article is adapted from his book* The Average Man Fights Back, *written in collaboration with Richard Hall, to be published next year by Doubleday.*

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plete—it does not take into account the role of preventive medicine—but it serves to remind us that our health depends less on scientific medicine than we usually tend to think.

Even within his own sphere, the doctor's infallibility is being increasingly questioned. The evidence comes in many shapes, including that of your television screen. After years in which the network reading of popular opinion dictated that doctors must be cast in the heroic mold of Kildare and Welby, NBC in the fall of 1975 launched "Medical Story" and "Doctors' Hospital," programs that portrayed doctors as being as afflicted with error and greed as the rest of us. Producer Abby Mann was aided in preparing "Medical Story" by Dr. Sidney M. Wolfe of Nader's Health Research Group, a leading critic of unnecessary surgery; the producers of Marcus Welby, who would never dream of committing any medical sin, get their cues from the American Medical Association. Johnny Carson and the authors of "Mary Hartman, Mary Hartman" take repeated jabs at the medical profession. "Medical Story" only lasted a season, and doctors still rate highest in the polls on which-profession-do-you-most-respect, yet, if televison either mirrors or molds public taste, what is appearing on the tube in 1976 seems to herald a shift in public attitudes toward doctors.

Getting what we need from the health industry begins by not accepting what we don't need. First on that list is unnecessary surgery. The fact that a lot of operations are unneeded has only recently begun to sink into the public mind. Within the profession, it has been discussed for decades, but only in the last few years has the message been broadcast to the laity by dissident insiders. Prominent among these is Dr. Wolfe of the Health Research Group. Using comparisons between the United States and Britain, and among Americans in different kinds of health plans, Dr. Wolfe estimated that 17 per cent of all operations are unnecessary, which works out to 3.2 million operations a year. The price tag is 16,000 deaths a year and a waste of $4.8 billion. Other estimates reach roughly the same conclusions. The reasons are clear enough: the nation has too many surgeons, surgery pays better than other medical work, and, under the fee-for-service system, the doctor who decides the operation is needed is also the one who gets paid for doing it—the legal equivalent would be for a judge to have a financial stake in the cases that come before him.

The chief victims, not surprisingly, are women, children, and the poor. Hysterectomy is what surgeons like to do to women; almost 700,000 of these operations were performed in 1975, resulting in about 1,200 deaths —from 15 to 40 per cent, depending on who's making the estimate, were avoidable. As a Baltimore specialist said: "Some of us aren't making a living, so out comes a uterus or two each month to pay the rent." For children, the leading unnecessary operation is tonsillectomy; the classic example is the doctor who, when one kid shows up with a sore throat, schedules all the children in the family to have their tonsils out on the same day. As for the poor, a 1975 study found that Medicaid patients are operated on at two-and-a-half times the rate of the rest of the population. Here greed is not the only factor: the poor provide most of the patients for teaching hospitals, and there just aren't enough sick organs around to supply the practice needed by interns and residents in surgery.

Avoiding an operation you don't need is ultimately a personal decision, but it can be powerfully influenced by the ground rules that surround the decision. Salaried physicians cut less often without valid reason than their fee-for-service counterparts—that's why surgery rates are much lower in Britain and Sweden. Thus the growth

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Harry Swanson

of prepaid health plans with salaried doctors is one way that unnecessary surgery is being reduced.

Another way is a second opinion by another surgeon who has no financial stake in the decision. This has been pioneered mainly in New York City, and the results to date are dramatic. In 1972, the small Storeworkers Union, with 8,000 members employed at Gimbels and Bloomingdale's, added a required second opinion, by a panel of salaried medical school doctors, for elective (non-emergency) surgery under its health insurance plan. They were soon joined by District Council 37 of the Municipal Employees Union, with 108,000 members, and an assortment of smaller unions with another 65,000; in these cases the second opinion was made voluntary. In 1975 Dr. Eugene G. McCarthy and Ann Susan Kamons of Cornell Medical School, which had set up the panels of surgeons to provide the second opinions, reported on what had been accomplished. In three years the second opinion had

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avoided 594 operations, which was no fewer than 28 per cent of the cases that had been considered. Hysterectomies and orthopedic operations were rejected at a considerably higher rate than other kinds of surgery, and specialists in those areas were found to be reaching for the knife more often than general surgeons. The program had cost $200,000 to run, and it had saved hospital costs of $1.5 million, plus a necessarily unknown number of lives.

The great leap forward came this year, when Blue Cross of New York began offering a free second opinion to some groups among its nine million members in the metropolitan area. "That takes a lot of courage," Barney Tresnowsky, a vice president of the National Blue Cross Association, had said of the idea when it was under consideration in New York. It was certainly a surprising act for the organization traditionally known as the hospitals' friend. But Blue Cross was being tormented with bad publicity over another rate increase, and less surgery is one way it can hold its premiums down. In any event, the step taken by Blue Cross in New York put the second opinion in the big leagues for the first time, and what is now on its way to being standard practice in New York is likely to spread rapidly to the rest of the country. (And what of the poor surgeon, already in surplus? Economist Gelvin Stevenson suggested that he might make his living as a consultant, giving opinions about surgery instead of wielding the knife, especially if he can convince health insurers of the need for a third opinion, to be known as the "tie-breaker.")

Unnecessary hospital stays are, if less dramatic than the operation you didn't need, another great waste of people's time and money. They come in two forms: going to the hospital when you don't have to, and staying too long when you do have to go. It happens because the nation has too much hospital capacity—the surplus of beds is variously estimated at from 67,000 to 250,000—and empty beds act as magnets attracting occupants. At its extreme, most notoriously in the Los Angeles area, hospitals buy patients from doctors at $50 to $100 a head; the price is right because, as one administrator said, "Whenever we purchased a patient, he never got out the door until he ran the bill up to $1,000. The payoff was $100, our overhead was $400, so that left us with a net profit of $500." Health insurance often pays for hospital treatment but won't pay for the same or an alternate treatment outside, and the health financing system generally has offered few incentives for keeping people out of the hospital.

Insurance that pays virtually all the costs of a hospital stay is also responsible for our choosing too often to go to the most expensive institution in reach: the operation may only be on the toenail, but, if the insurance is paying anyhow, why not choose the teaching hospital with the heart-lung machine instead of the lower-cost community hospital? The extra cost of each such decision is of course third-partied back onto the general public. The result of unnecessary hospitalization was illustrated during a doctors' strike in San Francisco in early 1975 when hospitals were closed except for emergency cases: the hospitals found there was no noticeable public demand for their missing services, and they concluded the public had been "spoiled."

The beginnings of change are visible. Walk-in surgery is increasingly available. Some 2,000 hospitals are geared to do simple operations without an overnight stay; the first to offer same-day service was Butterworth Hospital, in Grand Rapids, Michigan, in 1961. A couple of dozen surgical clinics do only walk-in surgery for about 40 simple operations; some 100 more such clinics are planned. Their record for safety is evidently good: one of the oldest, Phoenix

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Surgicenter, has performed 26,500 operations in five years without a death and without an emergency transfer to a hospital. The savings are equally impressive; some of the Surgicenter operations cost less than half the hospital price. A dilation and curettage, for example, in 1975 cost $121 compared to $265 in a Phoenix hospital (the prices do not include doctors' fees). The reduced-time surgery program of Southwest Ohio Blue Cross—known as "Verticare"—saved $250,000 in its first two years, and its members avoided more than 4,000 hospital days. In Washington, D. C., Blue Cross was taking ads to tout same-day surgery under the headline: "In by nine. Out by five." The ad concluded: "If programs like these succeed, they'll lead to improvement of health care for everyone. They may even save money."

Abortion is an operation that now, after an initial period of uncertainty, is done primarily outside hospitals. The fact that abortion is now legal by Supreme Court decision, and in practice ever more widely available, is of course a great success story in the politics of health. When New York State legalized abortion in 1970, and it was clear that it was first going to happen on a large scale in New York City, hospitals lobbied to restrict the action to their premises. But Gordon Chase, then the city's Health Services Administrator, pushed successfully for allowing non-hospital clinics to do early abortions, again at less than half the hospital price. After five years the clinics' safety record is as good as the hospitals', and certainly far better than the bad old days: in 1974 just one woman died during abortion, while in 1969, the last year before the law was changed, illegal abortions took the lives of 24 women. The success of the abortion clinics undoubtedly has been a factor in persuading people that many much simpler operations can be done without an overnight hospital stay.

Blue Cross, perhaps the single most important force in the field, has moved in various ways, often under pressure, to reduce unnecessary hospital use. In 1971, Herbert Denenberg, the famous Pennsylvania Insurance Commissioner, blocked a Philadelphia Blue Cross rate increase of 50 per cent and demanded that Blue Cross renegotiate its hospital contracts to reduce costs. The new contracts provided that Blue Cross would not pay for patients kept too long and would reduce its payments for costly underused equipment, of which the most notorious example is idle open-heart surgery units. As a result of the tougher contracts, nine per cent fewer Blue Cross members were hospitalized in 1972, and those that were spent seven per cent less time there; Blue Cross spending rose only 2.5 per cent in that year, less than the rise in the cost of living, compared to 67 per cent in 1969-71.

An increasing number of Blue Cross plans provide for pre-admission testing: you have presurgery tests done as an outpatient, and come to the hospital only when the operation is scheduled. According to Blue Cross, this can cut two days off the average hospital stay. Blue Cross also increased its benefits for home care. Currently about two thirds of Blue Cross plans offer some form of home care, and the savings can be dramatic: the Rochester, New York, Blue Cross reported, for example, that 220 of its members were being treated at home at an average cost of $18 per day, compared to $116 in the hospital. Both these moves by Blue Cross took courage, as the man said about second opinions, because they can only reduce business at hospitals already suffering from empty beds.

The effect of the various efforts to keep us out of the hospital when we don't need to be there began to be felt in 1975 when, for the first time in many years, the number of hospital admissions fell slightly, while the use of outpatient clinics rose.

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Harry Swanson

Another way of minimizing our need for the health industry's services is to reduce the hazards of the workplace, where each year 100,000 persons are killed and many times that number disabled. This is a major goal of the Health Research Group, but it is not easy to make headway when safety in the workplace appears to be of as little interest to most unions and government inspectors as it is to employers. When the group took on the case of Cleam Caldwell, a District of Columbia Metro tunnel worker who had contracted silicosis and then been fired for "unreasonable questioning of

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safety on the job," all Caldwell had gotten as compensation was $750—plus an offer of reinstatement in the same hazardous place; his eventual settlement was for $45,000.

Progress has been made on some fronts. Pressmen at Washington newspaper plants brought hearing specialists to measure the din at work, who determined that more than half the pressmen had suffered hearing loss; with the help of the Health Research Group, the pressmen made enough noise of their own to force the newspapers to install sound-reducing devices. Later the HRG set up a clearinghouse of hearing specialists to help other unions interested in muting the workplace. In Superior, Wisconsin, workers in grain elevators found that more than half their number were coming down with respiratory disease. With outside help from the University of Wisconsin, they uncovered the usual lax enforcement of inadequate standards and were able to force the employer to install new safety equipment; the improved standards resulting from the case will apply to 100,000 grain-elevator workers around the country. Governmental efforts to regulate safety at work, never more than a tiny fraction of what was needed to make any dent in the annual carnage, seem to be both rising and falling: the federal government's somewhat greater effort in recent years has been used by the states as a pretext to do even less than they were doing before.

The current boom in malpractice suits measures, as on a barometer, the public's rising desire to fight back and the willingness of some doctors to tattle on their colleagues. Malpractice claims are running close to 20,000 a year. In *The Great American Medicine Show*, Spencer Klaw cites a government survey that found about half the claims to be "legally meritorious." But far fewer than half who sue actually collect anything, and, as Klaw points out, the true rate of malpractice is far higher than the number of claims, since many victims are reluctant to sue or are unable to find a lawyer willing to take their case. Doctors have been howling in pain as the cost of their malpractice insurance has gone up in proportion to the judgments against them; indeed, the cost has gone up faster than the verdicts, since malpractice insurers pay out only one dollar in claims for every three dollars they collect in

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premiums, the rest of the money disappearing in overhead.

Avoiding the medical care we don't need does not, of course, guarantee us the care we do need. There is still a chronic shortage of primary-care doctors that makes most people glad to get a scrap of a physician's time, and encourages an attitude of unquestioning gratitude on the part of patients. If we are to be more demanding of our doctors, we need an adequate supply of them, particularly in primary care. If the number of doctors stays constant, any national health plan will only repeat the experience of Medicare and Medicaid, which increased demand for medical services without providing an offsetting increase in supply, and hence led to higher bills that the government and the average man footed.

The scarcity of doctors will soon be easing, it seems, almost three quarters of a century since the AMA instituted occupational birth control with its 1910 Flexner Report, which de-accredited half the nation's medical schools, keeping our doctor supply permanently insufficient. By the 1960s, the AMA's resistance had weakened, 27 new medical schools were started, and in 1975 enrollment was up by 70 per cent from 10 years earlier. Physicians in practice were up by 50,000, with considerably larger increases expected in the next two decades. The AMA, which had recognized the shortage it created for only about 45 minutes, now joyfully proclaimed that the problem no longer existed. If it seemed that doctors were scarce, we were told, it wasn't a shortage, just maldistribution: too few doctors in the slums and the boondocks, too many in the fat suburbs. The logic was feeble even by AMA standards, for, if the suburban practices are overcrowded, some doctors out there should be starving.

But medical malnutrition hasn't been observed anywhere recently, certainly not in the suburbs, though surplus surgeons are forced, if they cannot find anyone to operate on, to the occasional indignity of treating organs instead of removing them. The increase in medical school enrollment has been fueled by federal subsidies that supply almost half the cost of the future doctor's education. When it was suggested in Congress that once he had joined the nation's highest-paid profession, that doctor might repay the taxpayers' money that got him to that exalted position, the AMA roared in indignation. How, organized medicine asked, could you make the student repay money that he had never seen, it having gone directly to the medical school instead of passing through his pocket? The idea went nowhere. The consolation to the taxpayer, as he examines the bill handed him by a doctor he helped put through medical school, is that the bill would have been even higher if the federal subsidy had not increased the supply of doctors.

But the projection of an increased supply of doctors depends on the United States continuing to rob other countries who for years have been supplying the nation the doctors denied it by the AMA. As recently as 1973, almost half of all newly licensed doctors were graduates of foreign medical schools; some were Americans who couldn't find a place in school at home, but the great majority were from countries short of doctors, people who were lured here by better pay and amenities. The AMA didn't mind during the halcyon days of the doctor shortage: its members would get the suburban practices, while the Pakistanis worked the night shift in the city hospitals. But by 1976 there were mutterings about restricting the entry of foreign doctors. If that were to happen, if the United States were to stop looting other countries' health manpower—a good thing for both, since a doctor usually performs better in his own culture—the effect on the domestic medical market would be to cancel out the entire increase in

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American medical school production and guarantee a shortage of doctors for many years to come.

Tomorrow's primary care will come not just from more doctors, but from a new kind of health provider who is taking over part of the physician's job. It is a reversal of the centuries-old trend toward more specialization and longer training for the same work. First the witch doctor divided into priest and physician, and later the barber-surgeon separated into his component parts. Now a new occupation is moving onto the doctor's turf. It is called, for want of a better term, the physician extender, and, for reasons of historial accident, it comes in two versions, distinguished by sex rather than function: the nurse-practitioner, female, and the physicians' assistant, male (though there are exceptions to both.) These two occupations have multiplied so fast that they seem certain to be an essential part of tomorrow's health care package. Today they number about 10,000, and they are being turned out at a rapidly increasing rate. Most of us will, in not too many years, be getting at least part of our health care from a nurse-practitioner or a physicians' assistant.

The nurse's practitioner has moved onto the scene with little fanfare. Though the idea isn't new—the Frontier Nursing Service has been providing most of the primary care in a thousand square miles of Appalachia in eastern Kentucky since 1925—the modern era dates from Dr. Henry Silver's experiments in the mid-sixties at the University of Colorado in training nurses to assume some of pediatricians' work. Silver demonstrated that the pediatric nurse associate, as she is usually called, can replace the pediatrician for about three quarters of his duties, and that the clients—mothers as well as children—quickly came to accept, and sometimes prefer, a visit with the PNA rather than the M.D. As for the pediatrician, he was able to carry a greater patient load, and that, a federal evaluation politely stated, "proved to be an economic boon to the physician."

With Silver's experience as a model, the pediatric nurse associate has spread to other states and now makes up about half the nurse-practitioner population. Some are in private practice with pediatricians, but more are in public health institutions, with the largest single concentration being the 70 PNAs in the New York City Health Department. The city began sending nurses to Cornell Medical Center for PNA training as recently as 1972. By 1976, PNAs were handling one quarter of all patient visits in the city's network of 80 child-health stations, and they were beginning to supplant doctors in giving school physicals. (The city had also trained ten nurse-epidemiologists to investigate cases of infectious disease.) According to Margaret O'Brien, the director of Public Health Nursing who selected and supervised them, the PNAs have been fully accepted by parents, and on at least one occasion, a mother whose child saw a doctor because the PNA was absent called the PNA at home to ask if it was all right to follow the doctor's advice. Some problems missed by doctors have been caught by PNAs, not, in all probability, because the PNA is more skilled but because she devotes more time to each case. At the present rate, the nurse-practitioner will in not too many years outnumber the doctor in the largest public health system in the nation. The doctors, though not happy about the turn of events, have made no organized effort to block the gradual erosion of what was once their exclusive territory.

The nurse-midwife, the second most prevalent type of supernurse, is a modern throwback. She is succeeding both the old granny midwife, who still practices in some parts of the South, and the lordly obstetrician, product of the era of scientific medicine. She is

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trained to handle normal childbirth—that's 85 to 90 per cent of cases—with a physician available in case of complications. At first the nurse-midwife served mainly the poor, and with notable success: a number of big-city clinics used them, and in Holmes County, Mississippi, the introduction of nurse-midwives led in three years, from 1969 to 1972, to cutting the infant mortality rate in half.

Then, as the nurse-midwife began serving more than just a poor clientele, it became evident that quite a few women preferred her services to those of the obstetrician. That at least is the experience of Roosevelt Hospital in Manhattan, where since 1974 five nurse-midwives have been attracting a growing number of middle- and upper-middle-class women. For some the calculation is economic: the nurse-midwife costs less than half the obstetrician's price. But money is not the only, or even the primary, consideration. The director of the hospital's midwifery service, Dr. Thomas F. Dillon, had this to say:

"We have tapped a group of people to whom economy is important and we have tapped a group of people that are women-oriented. Beyond that, I'm sure we've tapped much more—something else. And right now I don't know what that is."

Some of the mothers who chose the nurse-midwife suggested what that something else might be. One mother, a pediatrician herself, saw no place for a physician—"trained to treat the abnormal"—in a healthy childbirth. Some viewed the nurse-midwife as a welcome change from a person in whose behavior they saw the classic male chauvinist pig. For others, the objection to the obstetrician was medical: he was more likely to use drugs to induce labor, and forceps in delivery, for his personal convenience. Although they were approved by the American College of Obstetricians and Gynecologists in 1971, when business was better, many obstetricians think nurse-midwives are a lousy idea—having just shoved the old granny out the back door, they find her daughter, dressed up in a diploma and, can you believe it, a goddam stethoscope, coming back through the front door. When the birth rate's falling! The obstetrician hasn't been able to slam that door, and as time goes by, childbirth will be available to more women on better terms—financial, yes, but also that "something else"—than it is today.

The physicians' assistant is a byproduct of war. More than ten years ago, the thought occurred to a few people that the civilian health industry could find a useful place for the thousands of medical corpsmen being discharged by the military services. These corpsmen were produced by a remarkably efficient training system, for, though the military squanders our money with the abandon of the Emperor Caligula, time is too precious to waste when training men who will only be in service for a limited stay. Through a series of brief, intense training stints interspersed with active service, the military produces, in what is called the independent duty corpsman, someone who is capable of supplying the health needs of a group of men, with only radio contact (if, for example, he is on a small ship) with a physician. Various ideas on how to make civilian use of this person coalesced into the concept of the physicians' assistant: someone to whom a doctor would delegate some of his tasks while always retaining ultimate responsibility for what the PA did.

The way of the PA was not easy, for, unlike his female counterpart, who grew out of the familiar figure of the nurse, nothing resembling the PA existed in the rigidly guild-bound health industry. Nor was he welcome; the nurse, in particular, threatened to brain him with a bedpan, or a lawsuit, if he got between her and the doctor. The first PAs, graduated from Duke University after two years of post-

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military training, were required to work only in the university hospital.

Dr. Richard Smith, designer of the imaginative MEDEX program for ex-corpsmen, toured the back country of the state of Washington looking for this prototype: a doctor with military experience who was chained to his practice because he was the only physician in that small town. Wouldn't life be easier, Smith suggested, if you had a skilled assistant, like those corpsmen you knew in the service, remember? So persuasive was Smith that the law legitimizing his program was pushed through the legislature by the state medical society. But progress did not always come easily. The doctors viewed the PA with mixed feelings. He spelled money in their pockets if they charged their rate for his lower-paid work—anyone could see that, and doctors knew better than anyone else how over-trained they are for most of their work. But, on the other hand, could they share the mysteries of the witch doctor? Dare they let an underling read those rattling bones?

The barriers began to fall rapidly when the AMA put its seal of approval on the PA, gaining thereby a hold on his throat by which one day it may be able to strangle him. By mid-1975, 37 states had legitimized the PA (nurse-practitioners in most states were able to function under their nurses' status without new legislation). More than 4,000 PAs were in practice by 1976, and they were being graduated at the rate of 4,000 a year, with that output sure to increase as training programs expanded (and drew on women and men without military experience). You could tell that the PAs had arrived when, having broken into the guild-ridden industry, they promptly formed a guild of their own: the American Academy of Physicians' Assistants. And you could tell, beyond any shadow of doubt, that the new guild had arrived from the following item from an account, in their newsletter, of the 1975 PA convention in St. Louis:

"Several drug companies sent representatives to the convention, where they distributed a great deal of literature and pertinent information through their exhibits. They also made it possible, financially, for us to have several social events including a very enjoyable evening aboard the Goldenrod Boat. Our thanks go to these companies. . . ."

(This did not mean the drug companies were neglecting the doctors; 1975 was also the year that six big companies banded together to start something called Physicians Radio Network. The sponsors were aiming at having 28 FM stations in the network by 1977; doctors, it was said, would be given free receivers for their network, which would broadcast "medical information" 24 hours a day. There would, the announcement said, be eight one-minute commercials per hour.)

Accounts of physician extenders' assignments tend to focus on the exotic: Mary Breckenridge, founder of the Frontier Nursing Service, galloping off to deliver another baby; PA Steve Brooks on the North Slope of Alaska, scraping injured pipeline workers off the frozen tundra. Many are indeed willing to go to locations too distant from the country club to attract doctors, but they are also moving into the mainstream where they will meet the average person. Their acceptance to date has been excellent; at this writing, not a single malpractice case involving a physician extender had been reported. Because they come much cheaper than doctors—most nurse-practicioners and PAs earn from $12,000 to $29,000—they will have, and we can afford, time for those ordinary problems, boring to the physician but of consuming interest to us, that are the common coin of health care. The physician extender, coupled with the rising output of the medical schools, may restore the Golden Age of American Medicine, that legendary time before World War I when there were enough doctors to go around. ■

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Why the Ambulance Comes Too Late

by David Thiemann

If you're going to have a heart attack, or get hit by a car, Seattle is one of the best places in the country to do it. Washington, D. C. is one of the worst.

If you go into cardiac arrest on the street in Seattle, a bystander will often start cardio-pulmonary resuscitation (CPR) immediately. Within three minutes a fire engine will arrive, and firefighters will take over the external heart massage and mouth-to-mouth breathing. An ambulance, dispatched simultaneously, will follow in a minute and a half, with professional paramedics who will try to restart your heart with an electrical shock. They will also give drugs to stabilize the heartbeat, transmit an electrocardiogram to physicians at the hospital, and obtain medical instructions by portable radio.

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If you're stricken in the District of Columbia, you might as well give up. There's no effort to teach CPR to the public. A fire engine usually isn't dispatched until an ambulance unit requests help—even though it would arrive in three minutes. So you'll wait eight minutes for an ambulance instead—or more, if you have the misfortune to collapse in the early evening, when calls for the city's eleven ambulances often stack up. The ambulance attendants won't be able to do anything but administer CPR and haul you to the hospital. Your brain will begin to suffer irreversible damage after four minutes without oxygen; by the time help arrives resuscitation will probably be hopeless.

If you're hit by a car in Seattle, or involved in a freeway crash, the ambu-

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lance paramedics will start intravenous lines to replace lost blood, and administer drugs to boost your blood pressure and forestall shock. If you're unconscious they'll slip a special airway directly to your lungs. They'll examine you thoroughly, straightening angulated fractures and splinting every possible break, before taking you to the hospital. When you arrive the emergency room team will diagnose your injuries, get X-rays and lab tests, and send you to the operating room.

If you're badly injured in D. C., the ambulance attendants will splint obvious fractures, apply pressure to stanch serious bleeding, and administer oxygen. Often they won't notice some fractures, so the jagged bone ends may move when you're lifted and, when the ambulance hits a bump, tear at your muscles, nerves, and blood vessels. If you're bleeding from the mouth or throat, or vomiting (a common reaction), you'll probably aspirate the liquid into your lungs, starving them of oxygen and causing eventual aspiration pneumonia. You'll arrive at the hospital with dangerously low blood pressure and volume—"shriveled up like a prune," one surgeon says—and in deep shock. The emergency room team will be working just to keep you alive.

In Seattle, one-quarter of the cardiac arrest victims the fire department tries to resuscitate live to walk out of the hospital. Six hundred people have been saved in the past five years. In Washington, D. C., almost no one survives. There are no statistics on trauma—that is, sudden injury—but experts estimate that Seattle saves at least 60 people a year who would otherwise die.

In the District of Columbia a system like Seattle's could save 250 lives a year. Nationwide, 340,000 heart attack victims a year die before they

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reach the hospital; at least 75,000 of them could be saved by adequate emergency care. Poisoning, overdoses, drowning, and trauma kill more than 120,000 people a year. (Trauma is the leading cause of death for children and for adults under 38.) At least 20 per cent of these people could be saved, and many of the eleven million disabling injuries a year alleviated. Yet only 15 per cent of the country is covered by paramedic systems.

What's the problem? Why are 100,000 people, most of them healthy and in their prime, dying needlessly each year?

Emergency medical care became a national scandal in the two decades following World War II. In the 1920s and 30s interns rode city ambulances, but specialization and suddenly expanding medical knowledge removed physicians from emergency care. A well-trained ambulance attendant in 1965 could do more to save your life than a doctor in 1940, but ambulance attendants generally received no training at all. A 1966 National Academy of Sciences study found that half of the ambulance service in the United States was provided by morticians—a conflict of interest that must have been depressing to the patients they carried. Eighty per cent of the attendants had little or no training, and three quarters of the ambulances did not meet minimal design criteria; many were actually hearses with a reversible sign.

The situation in hospitals was as bad. No one specialized in emergency medicine; emergency departments were staffed by interns and residents on rotation from other specialties, or by practicing physicians who worked occasional shifts in the E. D. Critical cases—victims of trauma, burns, heart attacks, and other life-threatening emergencies—were taken to the nearest hospital rather than the best one. Hospital administrators would threaten to cut an ambulance company off from nursing home transfers, the lucrative part of an ambulance business, unless it brought its trauma cases to their hospitals. Some negotiated contracts guaranteeing them all of a company's patients, even if another hospital was nearer and better equipped. Once it admitted a patient, a hospital would keep him until he died, rather than quickly transferring him to a larger, more sophisticated facility. Many patients who died hours after admission could have been saved at another hospital a few miles away.

This miserable situation stood in stark contrast to the state of the art. In Korea and Vietnam corpsmen administered drugs and intravenous fluids to wounded soldiers in the field before evacuating them by helicopter to field hospitals, where surgeons were repairing trauma that would have been fatal a few years earlier. Mortality statistics reflect the change: in World War I eight per cent of the soldiers who reached a hospital alive eventually died, compared to four per cent in World War II, two-and-a-third per cent in Korea, and two per cent in Vietnam. This occurred despite the fact that more critically wounded soldiers than ever before were reaching hospitals alive, because of better field care and quicker evacuation.

The situation in cities today isn't as bad as it was in 1966. By 1969, rescue squads in Miami and Los Angeles had begun using drugs, intravenous fluids, biomedical telemetry, and portable defibrillators to treat heart attack victims in the field. Cardiologists had also developed cardio-pulmonary resuscitation to keep a trickle of blood and oxygen flowing to a victim's brain until paramedics arrived. Together, bystanders who know CPR and paramedics might save half of the people who now die before they reach a hospital.

Ninety per cent of the ambulance attendants in the country have taken an 81-hour Department of Transporta-

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tion course in emergency care. Most ambulances meet federal specifications and carry adequate equipment. Emergency medicine became an accredited specialty in 1973, and more hospitals are hiring full-time emergency room physicians. And the hospitals, prodded by the federal government, are beginning to identify local and regional centers for trauma, burn, poisoning, and cardiac cases, and to send critical cases to them.

But few laymen know CPR, and few jurisdictions are developing paramedic systems. The expense isn't prohibitive: it costs $15,000 to convert an ambulance into a paramedic unit, and $5,000 to buy a hospital base station radio. Seattle's free three-hour course in cardio-pulmonary resuscitation, taught by firemen, has trained 120,000 citizens—at a cost to the city of $1.84 a person. But for some reason paramedic systems are spreading very slowly.

Emergency paramedical care is a classic example of something the government could provide, but doesn't. The reason isn't shortcomings in technology; that's all well developed and relatively simple. It's partly money, of course, but even that isn't the major obstacle. The root of the problem—and of quite a few other problems, for that matter—is that combination of petty politics and general ineptitude that is so common in American governments. The story behind the District of Columbia government's non-delivery of something it ought to be delivering is a sad one both specifically, for the lives it wastes, and generally, for its broad typicality.

The problems in the Washington ambulance system are obvious. It's operated by the fire department, which owns eleven ambulances that have to cover 80,000 emergency calls

Victor Scruby

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a year, more calls per ambulance and per 100,000 people than in any city in the country. During most of the day ambulance attendants drop a patient off at a hospital emergency department, radio the dispatcher that they're back in service, and are given another call. Half of the calls are dry runs, where a patient decides he doesn't want to go to the hospital after all, or refuses to be transported. Most of the others are "taxi-runs" for inner-city residents taking advantage of the free care and transportation.

There's no way to distinguish between what is and isn't a genuine emergency over the phone, so ambulances must respond to everything. The average response time is eight minutes, but during peak hours it may take an ambulance ten or fifteen minutes to get to a life-threatening emergency, and more than an hour to reach a minor case. The attendants are jaded—it's no wonder, since most of their patients are alcoholics, addicts, and psychiatric cases—and the ambulances themselves are grim. Half of them are old Chevrolet vans, with rough sheet-metal work and plywood paneling installed to convert them into emergency vehicles. They meet most federal standards, but have torn upholstery, ripped-up flooring, loose fixtures, and the like.

The ambulance service operates eleven units from 8 a.m. to midnight and eight in the early morning hours. It has a staff of 100 Emergency Medical Technicians. According to a consultant's report, that coverage should be doubled. Fire department administrators have managed to protect the ambulances from the worst of the District's budget crunch, adding one more unit and a few personnel while closing some fire stations at night. But any wholly new paramedic system would have to live within the existing budget, because the city has not earmarked any extra money for the program.

All this is not to say that Washington doesn't *want* a better ambulance service; indeed, District officials like the idea of a paramedic system. It's a political plum—a way for city officials to attract publicity and win votes as well as saving lives—and accordingly, it's been endorsed by everyone from Mayor Walter Washington on down. But political promises can't be redeemed in cash. A good paramedic program would require well-trained, well-paid personnel and more than $100,000 worth of new equipment—money that D.C., already financially beleagured, just doesn't have. So when the city worked toward a new paramedic program, it tried to get it with someone else's money. Like any city, it looked to the federal government for the necessary funding.

For quite a while no funding was forthcoming, and D.C. officials did essentially nothing about the paramedic system. Finally, in 1974, five years after other cities had proved that paramedic systems worked, an opportunity for outside money came along. The District applied for a grant from the Department of Transportation, and in June 1975 got $500,000 for a three-year "Medical Emergency Communications Coordination Assessment System." In English, that's a fancy radio network for paramedics, one that includes portable radios, telemetry between paramedics and emergency room doctors, mobile relay stations, and hospital base stations—virtually all the hardware needed to start a system. There was more money, too: $650,000 from the National Highway Traffic Safety Administration, and, from the Department of Health, Education, and Welfare, grants of $102,000 in fiscal year 1976 and $204,000 in fiscal 1977 for equipment and training.

The National Highway Traffic Safety Administration grant has had almost no effect. The District spends only ten per cent of it on emergency medical health care, and that goes to the maintenance of the conventional ambulance system.

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As for DOT and HEW, they give out their money in different—indeed, conflicting—ways, and the combination of their disputes with the District's attempts to play both sides of the game has resulted in an administrative chaos that has so far quite effectively stalled any moves toward a new ambulance service.

DOT gives its money to existing local governments, so that the District of Columbia got its grant. HEW is trying to create its own political geography, and its officials have divided the country into 300 regions that don't conform to existing state and county boundaries. HEW's grants go only to hospitals and cities that form regional organizations, so to get its HEW money the District has to cooperate with other nearby governments.

The logic behind all of HEW's complexities is that its system will work out best in the long haul. It uses its grants to force hospitals to organize regionally, and to set up specialized centers for each of six kinds of life-threatening emergencies, like trauma, heart attack, and burns. Patients in critical condition would theoretically be routed to the specialized centers, which in turn would mean better patient care at lower cost.

Now this all sounds wonderful on paper, but in interaction with local politicians and doctors it causes problems. Politicans are reluctant to sacrifice their autonomy and carry out someone else's guidelines. Hospital officials don't like to admit that their facilities can't provide some kinds of sophisticated care, or to lose the revenue from patients who would be transfered under the HEW system.

As a result, Washington and the suburban Virginia and Maryland counties that make up its region fought for months last winter over apportionment of the HEW money, and are still deadlocked about voting representation on the regional council.

Still and all, it seems as if Washington could have made some progress toward getting its paramedical program off the ground. After all, it had money. The necessary equipment can be ordered from a catalog, and the medical protocols and training procedures have been proved and refined in 50 programs around the country. But D. C. still doesn't have enough paramedics working on the streets.

The biggest bottleneck is the District's Department of Human Resources (DHR), which administers the federal grants. Its officials, afraid of bungling or attracting criticism, have delayed the paramedic system for months with meetings and memoranda. They seem so frightened and demoralized—or so incompetent—that they can't decide anything. Dr. George Hyatt, an influential advocate of the paramedic program, recalls that "we had to reassure DHR that, if it didn't work, they wouldn't be held responsible."

DHR has no connection with the fire department, which, you'll remember, runs the city's ambulances; it just holds the purse-strings. It's a classic illustration of a problem that afflicts paramedic programs nationwide: nobody knows who's responsible for them. Because they involve the fire department, the health department, emergency room doctors, and hospital administrators, as often as not the programs get lost in the cracks between the different organizations, or bogged down in interagency feuding.

The problems go beyond that, though. DHR has never hired a supervisor for emergency medical services who has had any experience in the field, and has never kept anyone long enough for him to learn it on the job. In two years it has shuffled three people through the directorship of emergency medical services, and it's now shifting the overall responsibility from one division to another as part of a department-wide reorganization. DHR has a staff of six working on

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emergency medical services, but all they do is arrange committee meetings, prepare transfer vouchers (to move money into fire department accounts), and shuffle papers between consultants, the fire department, and the federal government. It took DHR more than a *year* to hire a coordinator for its DOT grant, and he was the first DHR employee with experience in emergency care.

Here is how Marguerite Dalton, who once headed the emergency medical services branch of DHR, defends all the delays: "Things are very complicated in every field. You have to proceed very carefully to learn the various components and know what you don't know. You can't make hasty decisions. You have to be thinking all the time and considering the consequences of your actions. No person can foresee all of them. It takes a lot of conferring."

So conferring is what goes on. Everyone involved with the paramedic program is afraid of antagonizing DHR—renewed sniping could only bog down the program further—but their frustrations come out when they're promised anonymity. One person says of Emmett Banks, Marguerite Dalton's assistant, "Emmett's the ultimate bureaucrat—he won't say he doesn't have any background in this. Dalton's just another trimmer—she says yes to me and then does what she wants."

If it weren't enough for DHR to bungle money it already has, it also serves as the District's representative on HEW's regional council, and is helping bungle that too. It has spent most of its time squabbling with the suburban representatives about how votes should be apportioned, how the HEW money should be divided, and whether the DOT-funded radio system will be compatible with a simpler system planned for the suburbs. From these disputes D. C. has acquired a reputation as a spoiler and earned the lasting enmity of several suburban counties. This sort of petty regional feuding, more than anything else, has held up systems across the country. It's especially bad in metropolitan areas.

The trouble in Washington began about 1973, when the Robert Wood Johnson Foundation was handing out $500,000 grants for communications and system development. The regional council prepared a grant application, with the cooperation of D. C. officials; the District then submitted an application of its own. Since the foundation had a clear policy of denying duplicative applications, it rejected both. Either by ignorance or perfidy, D. C. cost the region a half-million dollars.

The next fight was over voting power. As the regional council was originally constituted, the District had only four votes of the 30 total, although it has one quarter of the region's population. However, DHR representative Dalton agreed to the arrangement, and DHR director Joseph Yeldell approved it, and the District signed the fiscal year 1976 regional application to HEW accordingly.

The $2-million application allotted $410,000 to D. C., mostly for manpower. But then HEW decided to reject all requests for manpower expenses. The Washington region received $800,000 instead of $2 million; DHR got $102,000—everything it had requested but the manpower allowance.

Yeldell screamed as if he had been robbed. He blamed the suburbs, ignoring the fact that HEW had done the cutting. He declaimed about the District's "integrity as a state," said the regional council "failed to protect D. C.'s geopolitical role," and accused the suburbs of trying to take "complete jurisdiction over the D. C. government in emergency medical affairs." He then refused to appoint representatives to the regional council in the summer of 1975, preventing distribution of the $800,000. The impasse continued until a new re-

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Memo of the Month

PRESS
DEPARTMENT OF STATE

February 24, 1976

No. 93

REMARKS BY
THE HONORABLE HENRY A. KISSINGER
SECRETARY OF STATE
UPON DEPARTURE FROM
RIO DE JANEIRO, BRAZIL
FEBRUARY 22, 1976

REPORTER: Mr. Kissinger, please say goodbye to the Brazilian people.

SECRETARY KISSINGER: Well, I want to say how much I enjoyed my stay here and how very fond I am of the Brazilian people: its marvelously spontaneous and human people. I hope to be back soon.

REPORTER: Thank you.

SECRETARY KISSINGER: Goodbye.

* * * *

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gional organization took over the grant in January 1976—and even now, DHR only sends observers to regional meetings.

Another regional imbroglio, over the compatibility of two radio systems, began as a technical dispute between consultants for the District and the suburbs, but quickly escalated into a pitched battle between HEW, backing the suburbs, and DOT. The problem was simple: when D. C. unveiled its DOT project, the suburbs had already planned and begun implementing a paramedic-to-hospital radio network of their own. The suburban scheme uses on-the-shelf, readily available components; it's simple and cheap.

The DOT system's designers rejected the suburban approach in favor of a more efficient system. Their plan costs more, and requires specially designed and manufactured components, but DOT officials say it will give D. C. the best communications system in the country. It can handle several simultaneous incidents and lets ambulances cross county lines without changing channels, but there's a catch: it requires a central authority to regulate the channels, so that two units don't try to use the same frequency at once.

The two proposals moved smoothly along side by side—DOT signed off on the suburban plan, and the suburbs approved the District plan—until an HEW communications specialist realized that they would create "destructive interference" when D. C. tried to use a channel one of the suburbs was already on.

A battle of consultants began, and DOT and HEW quickly joined in support of their respective clients. In a series of stormy meetings, HEW said that D. C.'s radio system was poorly designed and unlicensable, and threatened to withhold its money if D. C. refused to accept the suburban plan. DOT ridiculed the suburban plan as primitive and claimed there would be no interference. The two consultants involved nearly came to blows, denouncing each other for shoddy work and professional incompetence.

The haggling brought both systems to a standstill from the fall of 1975 through the spring of 1976. After the White House Office of Telecommunications Policy intervened and the quarrel attracted scathing newspaper editorials, the parties submitted it to the Federal Communications Commission for informal arbitration. The FCC developed a face-saving compromise to assure compatibility: D. C. would develop its fancy system, but for the time being would operate within the suburban plan.

So things stood on February 5, 1976, when U.S. Judge John J. Sirica suffered a near-fatal heart attack while giving a speech at the Army-Navy Club. Although his heart stopped, Sirica survived. The U.S. marshall guarding him, and then a D. C. ambulance crew, administered CPR, and doctors at George Washington University Hospital were able to resuscitate him. But a few physicians had finally had enough of DHR's casual progress toward a paramedic system. In press conferences and television interviews they linked the judge's brush with death to the stalled program. Dr. Joel Gorfinkel, the cardiologist attending Sirica, lectured about DHR in a press conference on the judge's condition. Dr. Sander Mendelson, another cardiologist, leaked the story of DHR's bickering with the suburbs to *The Washington Star*, which crusaded against the agency in a two-part series and a scathing editorial. It blamed "dilatory and arbitrary administration" in DHR for the delays. Television reporters picked up the story, grilling DHR officials and providing a friendly forum for Gorfinkel, Mendelson, and other doctors.

This shrewd manipulation of the media (Mendelson has a "reliable

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source" sign in his office and says that "DHR is very careful about what they tell me now") worked remarkable changes in DHR and the fire department. DHR settled the radio dispute and dropped its tirade about the regional council. Fire department officials decided not to wait for new equipment and rushed ahead with a training program for paramedics.

The course was thrown together fast. The fire department asked Georgetown University to start it in a week; the doctors bargained for time, and eventually began teaching it two months later. That slapdash approach has characterized the program ever since. On the Friday before the paramedic course was to begin, the city corporation counsel's office ruled that city insurance did not cover the paramedics while they practiced on patients in the hospital. Dr. Sam Hawken—the Georgetown resident in orthopedics who put together the course—ended up calling insurance brokers himself and arranged coverage. Dr. George Hyatt, chairman of orthopedics at Georgetown and head of the DHR EMS emergency medical services committee, paid for the insurance with a personal check.

The course itself had problems as well. The paramedics weren't able to practice with a portable defibrillator and radio, because the city hadn't gotten the equipment yet. They did watch surgeons in operating rooms for three weeks, four hours a day—time largely wasted, because paramedics won't perform any surgical procedures. They did not have a chance to observe the delivery room, although obstetrical emergencies are common in the field. The course ended as it began, with political opportunism: it was cut two days short so that the city could brag about its new paramedics on the Fourth of July.

The paramedics finished their training three months ago, but they haven't yet started an intravenous line in the field or defibrillated a heart attack victim. They're stationed at the Washington Hospital Center, so they

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can maintain their skills by observing in the Emergency Department, starting IVs and administering medications. They respond to calls in "Mobile 25," which *The Washington Post* touted as a paramedic unit "just like TV." In fact it's a glorified ambulance. Since it doesn't have communications with the hospital, it doesn't even carry drugs, intravenous fluids, or a defibrillator.

The 17 paramedics—enough to staff one unit 24 hours a day—are angry and demoralized. "Nobody wants to tell us what's happening," one says. "It's 'We'll worry about it and you just do it' from all the brass. What's going to happen is another Sirica, and then all of a sudden we'll be running around two days later." The situation is especially galling to the paramedics because most of them have extensive experience in the procedures they're not allowed to perform. Many were military corpsmen with field experience; others have worked as cardiac technicians or licensed practical nurses in hospitals.

Pay is another continuing problem. Trained paramedics are in tremendous demand nationwide. In neighboring Montgomery County, a paramedic starts at $12,000; a D. C. fireman starts at $12,300. But some D. C. paramedics, who are civilians rather than firefighters, are classified as GS-4 and GS-5 civil service employees, earning less than $9,000 a year. "You can train a gorilla to hold a hose," Fire department battalion chief Joseph Shelton says. "I think skilled paramedics deserve at least as much money."

Unless D.C. boosts their salary and develops a career ladder for paramedics, many say they will quit when their nine-month commitment expires. The District, unwilling to spend its own money to pay them adequately, is still expecting to sponge off DOT. "DOT's not going to let their program fall flat on its face," Dr. Hyatt says. "They're taking a paternal interest in it." Shelton says the fire department needs to develop a job classification for paramedics before it can increase their salaries, and admits he doesn't know where the money would come from.

There are still a lot of problems the District hasn't even begun to grapple with. The system still lacks a full-time director with the medical credentials and political skill to push it through. The number of paramedic units now in the city's ambulance service, and their operating budget, are still uncertain. The fire department also hasn't yet decided how many paramedic units it will have, where they will be stationed, what calls they'll respond to, and what hospitals will supervise them. Fire engines still don't respond to life-threatening emergencies, so ambulances and paramedics will usually arrive too late. And the District hasn't even begun to consider an educational campaign like Seattle's, so its system will probably have a save rate of about five per cent, rather than Seattle's 25 per cent.

This all sounds like a horror story, but Washington is not an exception. It has some special problems, but the country and officials at HEW say the bureaucratic delays, regional politics, and financial troubles that have delayed its system are similar to the problems in many other regions.

Statistically, Washington is actually ahead of most of the country. In its annual report on the emergency medical services program, HEW said that 65 regions aren't receiving any money because they haven't begun their programs; 125 have received small planning grants; 74 are upgrading their ordinary ambulance service; and 36 have begun paramedic programs.

"In a small town it's so simple," Shelton says. "You buy some equipment, make some arrangements with the hospital, train your people, go to the drugstore and buy some drugs, and go out and operate.

"It seems so simple—and then it all gets muddied up." ■

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A Harvard Man Discovers Free Enterprise

by James K. Glassman

You probably wouldn't be surprised if I told you that the people I went to school with—the ones who marched on the Pentagon, sat in against Dow Chemical recruiters, and took over college administration buildings—didn't grow up to become small businessmen.

It's a shame they didn't, too, because, as a sit-in veteran and small businessman myself, I'm convinced that entrepreneurship is the last refuge of the trouble-making individual—or, if you prefer, the creative individual, the person outside the established order of big business, big government, and big foundations. I'm convinced that the kid who was taking over buildings in 1969 has a lot more in common with someone who started his own pizza stand than he does with lawyers, corporate managers, and bureaucrats.

But lawyers, corporate managers, and bureaucrats are what the overwhelming majority of my Harvard classmates have become: what they're doing is serving, basically as consultants to whoever will pay for their advice, the same leviathan they railed against in college. In a way, you can't blame them. Many of them never understood that they could still achieve, be creative and productive,

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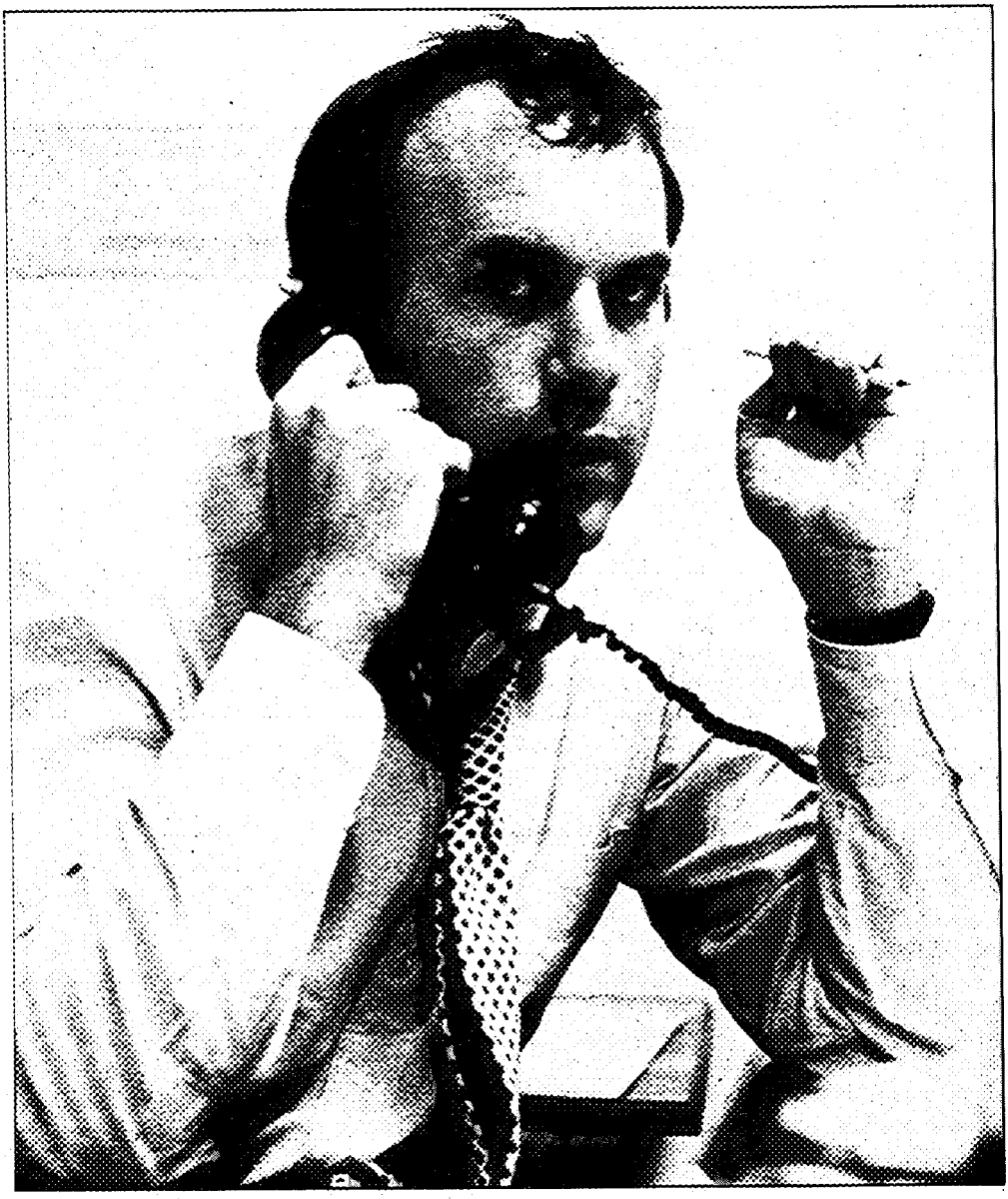
FIGARO



James K. Glassman: "As a sit-in veteran and small businessman myself, I'm convinced that entrepreneurship is the last refuge of the trouble-making individual."

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outside the system. If they saw all too clearly its flaws, they were still tied to it because their only standards of success and fulfillment were external. The only alternative they could see to joining up was not achieving at all, dropping out, and that was out of the question. Even if they did search for a place to achieve outside the world of giant law firms, they certainly never would have considered looking at pizza stands. To them—and to me too at the time—there was not much difference between small business and big business.

It's too bad that our distinctions worked the way they did. As a result, this country is being deprived of the considerable (by our own account, anyway) creative talents of nearly a whole generation of well-educated people. Instead of striking out on their own, most of them are oiling the machine—and they're probably not even enjoying themselves.

I don't mean to say that entrepreneurship (which we can define broadly as the starting and running of one's own organization) is pure enjoyment. Starting a business is exhausting, nerve-wracking, depressing, and (in the early stages) not in the least rewarding. Entrepreneurs are not conspicuous money-makers. Three-quarters of their ventures fail in the first year of operation, often leaving them with massive personal debts.

So why do people become entrepreneurs? For me, it was a natural thing to do, an extension of the creating-and-achieving ethic I was brought up on at home and in college. Also, I like being on the line; I like the pressure and the constant self-testing; I like feeling like I'm creating something useful every week; and I like being alone against the big boys. Whatever the entrepreneurial spirit is, it seems to me to be quite similar to the rebelliousness of the 1960s. The radicalism that I knew—not the drab, dull group-orientation of the Progressive Labor Party and its ilk, but the fun (and still meaningful) existential stuff—isn't inconsistent with what I'm doing today.

Not a single one of my friends from my college days—only eight or ten years ago—is an entrepreneur today, and none of them is likely to become one. An extensive study of MIT graduates a few years ago showed that if you don't start a business by the time you're 30, you'll probably never start one.

Take my word for it: entrepreneurship in this country is on the decline. There are no authoritative statistics on the subject, but a few indicators can be pieced together.

There are more than nine million small businesses in America, representing 95 per cent of all businesses—but all that is by the government's generous definition of "small": anything with less than $7.5 million in assets and $250,000 in net annual income. The number of small businesses increases at the rate of about 50,000 a year—but the size of the country is increasing faster. Ninety-four per cent of manufacturing companies are small—but they employ only 21 per cent of all the manufacturing workers in the nation.

The balance of the nation's capital is tilting more and more toward big companies, and only about 1.5 per cent of the American work force is made up of what the Census Bureau calls "self-employed owners and managers." The venture capital firms that proliferated in the 60s are withering away, and banks are tight with their loan money. At the business schools and law schools, it's the rare (usually, in fact, the unsuccessful) graduate who strikes out on his own; entrepreneurship there is on a distinct decline. The encouragement to start a business simply does not exist for young people these days because of the economy and the educational environment. "If we wanted to design a system of schools to prepare people solely for life in large institutions," says Francis Fisher, director of Harvard's career placement office, "wouldn't we just keep it the way it is now?"

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Innovation and the Individual

Anyway, what bothers me is not the numbers, it's the quality of small business. It's clear from simple empirical observation that the best members of my generation aren't becoming entrepreneurs, that a lot of people who could be creating and producing are merely advising and helping things along instead.

What's wrong with that? What's wrong is two things:

■ Small business has traditionally been the main innovative force in the American economy. At least part of the economic troubles we've been having in recent years—including our miserably low productivity rate—is the direct result of a lack of innovation in business. Successful big businesses tend to be preoccupied with maintaining the status quo—keeping their market share or increasing it a few percentage points at the expense of their established competitors. Small businesses simply can't survive unless they have a better product or a better way of doing things. So successful small businesses almost always introduce new, valuable, creative ideas to the marketplace and stimulate the economy. A decline in entrepreneurship means that this innovativeness is being lost to society.

■ Small business is one of the few endeavors in which the individual is the whole show. A decline in entrepreneurship indicates that fewer people—especially the talented, well-educated ones I'm talking about—are willing to be tested on their own merits. It's ironic that as America gets more meritocratic, as economic advance is open to more people, it gets increasingly systematized in a way that discourages people from striking out on their own. Why, if you're bright and young and college educated, should you start your own business when there's far more security and money in going to law school? It used to be that professionals made less money than they do now, and had less completely assured futures. Now a bright young person can, by the age of 30, have lifetime tenure in a high-paying, well-respected job—and with those powerful allures at work, the creative impulse assumes a low place in the hierarchy of motivations. The more organized and institutionalized our society becomes, the less bright people have to deal with failure, because to succeed they need only take each succeeding step on a well-trod path, without somehow botching it.

That kind of security can be a good thing, but it can also magnify far out of proportion people's fear of failure. My college friends had been following the path all their lives, from the time they took their first standardized test just out of infancy, through admissions offices and tracking systems all through school, past transcripts and recommendations and summer jobs; and they had never failed. As a result, they seemed to feel that if they stepped off the well-trod meritocratic path for even a few years they'd never be able to get back on. If most Americans are unwilling to test themselves in this way, then there is little hope for any kind of political, economic, or social change—all of which involve personal risk.

The Shoe Repair Shop

When my wife and I started our small business, a weekly newspaper in New Orleans, four-and-a-half years ago, we certainly didn't do it with the good of the American economy in mind. In fact, it's hard to say what was in our minds. For one thing, we didn't have any entrepreneurial consciousness at all; we didn't think of ourselves as *starting a small business*, the way that, say, someone starting a dry cleaning shop would.

At the time, I was a journalist who wanted to start my own paper, the way a chef would want to start his own restaurant, or a poet his own small press. Most journalists who undertake this sort of thing learn very quickly that what they're in the midst

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of is a business, and their main preoccupation becomes staying alive. I never wanted to make a lot of money, just *some*, enough for a small profit—you'd be surprised how difficult that is and how suddenly in awe you are of the guy with the shoe repair shop who's managed to stay in business for seven years.

Worrying about meeting payrolls and collecting overdue bills is hardly what I had in mind when I started the paper, and people like me usually realize suddenly that they've made a mistake. They usually get out and cut their losses or stay in and feel miserable. The same pattern, when it hit me, turned out differently—I stayed in, and loved the business of it. When I first started thinking about the newspaper venture, after graduating from college, Michael Janeway, the executive editor of the *Atlantic*, warned me that I'd be spending all my time worrying about getting advertising. At the time, I simply didn't believe him. Now I've found out he was partly right—I don't spend *all* my time on advertising, but certainly a lot of it—and I don't mind a bit.

So in a sense I underwent a metamorphosis in the middle of starting a business, and discovered entrepreneurship by accident. I think the attributes that I had that made entrepreneurship palatable, even exciting, to me are shared by my old classmates. Psychologist David McClelland lumps these attributes under the heading of "the drive to achieve," and, in his terms, my classmates were indeed achievement-oriented. The urge to strike out on one's own, however, is not one of their achieving motivations, and their route has been the conventional one for someone graduating from an Ivy League college in the 60s and 70s: on to the best law school or business school possible, then to the best firm possible (usually the biggest), or the consulting route, or the government route, or the university route. All are really the same, already mapped out for you. Certainly there were tests along the way, but there was little risk. You knew the rules and the patterns of self-testing and achieving—after all, you had followed them since grade school—and there was little chance of your failing.

To an extent, the entrepreneur follows these same patterns as well, but somehow the quantum leap is made—the fear of failure overcome, maybe—and he ends up being outside the leviathan instead of part of it. I am not sure exactly why the entrepreneur makes the leap, but I am fairly sure why the others don't. It's tough to start your own business today for two sets of reasons, one having to do with money and one with people.

Money

In 1976, you can't simply go out and start your own steel company or electric company or daily newspaper. Those markets are already sewn up. Even if you saw a weakness in, say, the aluminum industry, even if you had a new way of making aluminum, raising the capital to enter that market is close to impossible. (A New Orleans firm, Toth Aluminum, has found this out. Charles Toth owns the patent on a formula that some experts consider a major breakthrough in the aluminum-making process. The usual next step would be to sell this patent to a large aluminum producer, but Toth won't do that. He's a hard-boiled entrepreneur and he wants to do the manufacturing himself. As a result, his company has been struggling along for ten years, unable to raise even a tenth of the capital needed to build a pilot plant to try out the process.)

Of course, the barriers to entry in industries like steel and daily newspapers were massive 50 years ago too. What has happened recently is that these barriers have extended to much smaller ventures, the kind that depend on a single brilliant invention (like the Polaroid camera). There has been a good deal of moaning and groaning in the business press lately about a "capital shortage" that faces big industry—utilities, manufacturing, even

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oil. But the shortage (if it really is a shortage) seems to be affecting small businesses and new businesses far more. As John Birkelund, president of the American venture capital arm of the Rothschild interests, wrote in *The New York Times* recently, the talk about the capital needs of big business "is based on the premise that there is, or soon will be, a serious shortage. But it is possible to argue that for the next year or two at least, the major problem is not an overall shortage of capital, but rather the way capital is allocated. The fact is that access to capital by our smaller and more marginal economic units has become steadily more constricted."

The "smaller and more marginal economic units" are the 95 per cent of businesses that are classified as small. Birkelund marshals impressive evidence that money for investment is being concentrated in fewer and fewer hands. For example, deposits of the ten largest banks have risen from 20 per cent of total U. S. deposits in 1962 to 33 per cent in 1975; the number of securities dealers fell from 4,800 to 2,900 in the same period. And those fewer and fewer hands are providing money for fewer and fewer large corporations. In 1962, Birkelund points out, the difference between the yield on a bond issued by a company with a rating of Aaa (solid, large corporation) and that issued by a company with a rating of Baa (usually smaller, slightly riskier), was only a little more than half a percentage point. Today the difference has increased to one-and-a-half percentage points. The smaller firms are being left in the cold, having to pay more for the money they need—if they can get it at all. The same thing is happening in the stock market, where the Dow Jones Industrial Average (which includes only hotshots like DuPont and U.S. Steel) rose 50 per cent between 1962 and 1975, while the Value Line Index, a more democratic indicator of 1,500 New York, American, and over-the-counter stocks, rose not at all.

It's not easy to raise money to start a small business. It's a lot easier, certainly, to borrow funds to go to law school or business school. But while you do need money, you shouldn't go overboard on the financial issue. The aluminum plant may be out, but it's not impossible to raise money for more modest ventures. You may have a friend with a few thousand he can afford to risk—or a friend of a friend. If you look hard enough there's usually someone. And if you can't convince *anyone* to invest in your idea, then it's probably not a very good idea to start with.

We started our paper on $20,000 in equity capital, put up by three people, and $20,000 in bank debt. The source of the $20,000 can best be described as "family money"—probably the most typical source of funding for a new venture. Over the years we put more money into the company, took on a few more stockholders, increased our bank debt. Money has always been a problem for us, but it is not *the* problem. More importantly, I have come to the realization that simply pumping more money into a company isn't a solution to anything; it doesn't stop the hemorrhaging.

The point is that if capital were more easily available, more people would go into small business. And while the financial barriers to entry get worse every year, they aren't insurmountable—at least not in every business.

People

To some people, I'm sure, the main deterrent to starting a small business is the social unacceptability of entrepreneurship. Among liberals these days, it's somehow idealistic to go into a policy planning consultantship and base to be a building contractor. When I'm invited to a fashionable cocktail party in New Orleans it's because I'm an editor, not a small businessman. And despite the lip service that politicians and social leaders pay small business, it's not highly regarded in

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civic circles either. Entrepreneurs rarely head symphony drives—not until they get rich and established, anyway.

But while these personal factors are significant, there are others still more important—like family background. The MIT study found that fully half the entrepreneurs surveyed had self-employed fathers. As large institutions become more important in our society, fewer people (especially in the education group I'm talking about here) are self-employed. There are fewer entrepreneur-fathers to have entrepreneur-children.

I'm always amazed when I'm asked, how did you start your newspaper? Really, it was the easiest thing in the world. The question implies that there are forms to be filled out, permissions to be gotten, the vaunted tangle of federal regulation to thread one's way through. All that is largely a myth; you won't get much help from the government in starting a business, but it won't bother you much either. Actually, it was a cinch: get a little money together, print a paper, and you're in business.

People's questions about my starting the paper and my reactions to them provide a good example of the difference in mind-set between the conventional achiever and the entrepreneur. I know how easy it is to go into (and out of) business because business has been a part of my own life—the background noise at home—for so long.

Pancho Villa and Rent-a-Cars

A few months before he died, my grandfather kept my wife and me up all night one night in Norfolk telling us his life story: how he was sent to reform school in Washington for breaking a window and not being able to come up with 50 cents to replace it; how he escaped by hopping a freight train in the dead of winter (hoping it would go south but ending up in Buffalo practically frozen to death); how he joined the Army at 15

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and went to Mexico with Pershing to fight Pancho Villa; how he returned to Washington, joined the police force, and got shot in a race riot, resigning in protest when the man who shot him got a light sentence.

There's no way to tell how much of it was apocryphal, but the story went on and on, and to me the most interesting parts were about business. My grandfather, for example, invented the rent-a-car. He was running a garage in downtown Washington in the early 20s (this after a record-breaking stint as a Sunshine Biscuit salesman), and one of his customers brought in a demolished old Ford that needed two weeks' worth of body work. The customer suggested that my grandfather rent him a used car for two weeks, and that gave my grandfather the idea of renting cars to people who didn't own them, to use on dates or trips to the country. He placed a classified ad in the *Star* that said: "Rent a car; U drive it," and the next morning there was a line of aspiring car renters stretched around the block in front of his garage. My grandfather also invented the zone system for Washington taxicabs, helped found the Fontainebleau Hotel in Miami, and, with my father and uncle, built the eponymous Glassmanor, one of Washington's first suburban developments.

I am not sure what motivated my grandfather (or my father after him, who became a home-builder and then a general contractor on his own), but I think he provided the groundwork for my own career. He was a risk-taker who seemed to be in the game for the sheer joy (and pain) of the gamble. He did everything in extremes, and even his biggest gambles (he once lost $20,000 in a night at the gin rummy table) were all his own; they seemed to be within his control. Anyway, I hope they were. I am that sort of gambler too. I can't stand betting on the dogs or the trotters—only the thoroughbreds, which I consider a matter of science.

And that brings me to my final point. The final characteristic that the entrepreneur has that all the acheivers I grew up with don't is a willingness to put himself at risk. There is no other endeavor (except perhaps professional sports or the arts) where success and failure mean so much. The vast majority of small businesses fail, with a horrible finality that a lawyer who occasionally loses a case can't understand. The first thing my banker told me when I asked him for a $20,000 working capital loan was, "You know [grinning], three-quarters of all businesses fail in the first year." Not only that, just five per cent of the businesses that are started today will be around in 1986. (Unfortunately, if you look at who's starting businesses today, you won't be surprised by that statistic.) And the figures themselves are less important than the concept of failure.

Failure is a totally personal event to the entrepreneur. In the depths of our business, about two years ago, if we had failed, I probably would have found good reason for it: the city, I would have told myself, wasn't ready to accept a good paper. But that's the justification of an artist, not a businessman. If the city wouldn't accept the paper, then we should have found it out and not started one. The venture is personal and the failure is personal, and the debts—about $100,000 of them—are personal too.

Tell someone your name (not your house, your name) is $100,000 in debt and he'll say something solicitous like, "How can you sleep at night?" I sleep very well, thank you, because my wife and I have created something on our own. If I have added pain and responsibility, I have acuter pleasures than most people as well. A few weeks ago I showed my banker black ink, our first year of profits. It felt good, no doubt about it, but curiously, the feeling was not one of self-satisfaction. I had the sense that this thing wasn't over, that the struggle would go on forever, that the adventure would continue—just the way I want it to. ■

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Why Other Harvards Aren't Discovering It

by Charles Peters

In the preceding article, James Glassman laments the fact that our best and brightest young people are not becoming entrepreneurs. I think there are four reasons for this failure.

One is the way the challenge is presented. *Time* magazine recently published an essay entitled, "Profits: How Much Is Too Little?" that asserted, "Without a hope of reasonable profit, no one would start a business, introduce a new product or service, or even continue producing an old one."

In other words, money is the only motive for the entrepreneur. What a narrow and unexciting view! Of course profit can be one motive. But how about the others—the joy of creating a new organization, of providing people with work, of making that work satisfying, of providing a product or service of the highest quality? None of them requires profit. All you have to do is break even. In fact, it is entirely possible that seeking profit could lead you into, say, shoddy products or unsafe working conditions.

Entrepreneurs do not have to be greedy monsters or dull Babbitts, as they are usually depicted in art. They can be humane, adventurous, creative—the qualities young people are supposed to admire, the qualities the country desperately needs if we are to revitalize our economic and political system. Too many of the people we now have in our large corporations and government agencies are bland, cautious, and unoriginal.

Another reason for the absence of entrepreneurs is the dearth of practical information on how best to become one. Here, to illustrate the problem, is the kind of advice needed by someone humane, adventurous, and creative who is starting out in business. As you read it, ask yourself if you have seen this sort of thing discussed anywhere else; I very much doubt that you have.

Finance your new organization yourself if you possibly can. If you can't swing it on your own, seek investments from friends or employees who share your aims. Or borrow the money. A second mortgage on your home might do the trick. The last thing you want to do is sell stock to the public—that gives you an obligation to those outside stockholders to maximize profit, which could be death to all the good things you wanted to do, all the fun you were going to have.

The best solution to the financing problem is to do it jointly with your employees. Then together you can make decisions to sacrifice profit in favor of such things as quality of product and quality of work. Or together you might decide to plow profits back into a new plant, instead

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of distributing them to stockholders. The *Time* essay mentioned earlier describes how Levi Strauss & Co. "generally retains nearly 90 per cent of its profits for reinvestment, like the recent offering of a new plant in the little town of Roosevelt, New Mexico. The plant created 350 new jobs . . . . "

The secret here is that the controlling stock in Levi Strauss is owned by one family, who can decide to forego dividends, just as you and your friends and employees could.

A third reason for the lack of entrepreneurship is that government policy does not encourage it. There is of course the Small Business Administration but it, to put the matter simply, is a joke that has traditionally been the preserve of the grubbier hangers-on to the incumbent administration and to its chief congressional patrons.

The capital gains tax break is now given to investors without regard to whether their investment is new or not. The result is that it encourages trading in existing issues as much as it does the financing of new enterprise. This country now ranks 18th out of the top 20 industrial nations in new investment. What we should do is restrict the capital gains break to investment in new plant or new business. This would encourage the entrepreneur and produce new jobs as well.

The final reason for the shortage of entrepreneurs may be found in the attitudes and values of today's youth. There is always a tendency to sentimentalize about young people, and the foregoing has assumed that given the right challenge and the right information, the young will react in the right way. That may not be the case. Today's young achievers are achievers in terms of grades, in terms of others' views of them, not in terms of their own view of themselves—as they go forward from the academy to work, they still need someone to grade them. And in our meritocracy, the most widely recognized post-school grade is the amount of money someone else will pay you to work for him.

Young people also want to make a lot of money so they can buy a lot of things. They are children of the television, shopping center, consumerist age. Their knight in shining armor has been Ralph Nader, the protector of those who buy things.

The great irony is that the acquisitive and the entrepreneurial drives can be inconsistent. If you can make $35,000 or more a year working for someone else, get your A, and buy those things, why risk all starting a new business?

The entrepreneur need not be immune to the acquisitive instinct but he must be willing to delay its gratification. If you want to be sure of having a nice house, you're going to be reluctant to risk that second mortgage to finance your new organization. And if you continue to want to get good grades, you're going to continue giving the safe answers at the very time when we've found that a lot of the old answers don't work and that our greatest need is for fresh and original approaches to our economic and political problems. ■

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We learned in SNCC that you had to construct your own alternatives. On the one hand, you held out a vision of what society ought to be, and at the same time, you tried to construct a working model of one aspect of what it could be. We didn't just make the demand for federally-subsidized day-care; we went out and set up a day-care center in the town.

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The Mailer~CIA Connection

by Tom Bethell

At any given time there aren't too many writers who can convince editors to publish splashy cover stories on the strength of their name alone. One such writer today, clearly, is Norman Mailer, who was identified recently in *The New York Times Book Review* as "our greatest living American-born writer," but whose recent lengthy article in *New York* magazine, "A Harlot High and Low: Reconnoitering Through the Secret Government," marks him down rather as our greatest pen-wielding celebrity, the balance of whose mind is beginning to show signs of being disturbed. "MAILER on the CIA" it is grandly titled on the cover, in letters nearly two inches high.

The article, which occupies 19 pages of the magazine, starts off with an illustrative device that is quite familiar to students of conspiracy-thinking: small pictures of a number of prominent people, some of them alive (Chuck Colson, E. Howard Hunt, Fidel Castro, Henry Kissinger), some of them dead (John Kennedy, Robert Kennedy, Marilyn Monroe, Howard Hughes), and they are all connected up by a crazy cobweb of lines with arrows on them. Aha, one immediately realizes, they're all linked up! Mailer is telling us that what we had not hitherto seen was that these people, diverse and separate though they may have seemed, had been all along burrowing like moles underground, hidden from view, working silently and secretly together toward the achievement of some common, nefarious goal, one that was inevitably contrary to the interests of the nation as a whole.

About a third of the way into the article Mailer gives us fair warning, in what seems to have been a moment of uncharacteristic lucidity. "If we have been entertaining ourselves until now with the illusion that we are pursuing a narrative," he writes, "or hovering over a picture that will soon come to

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focus, we may as well recognize that we can count, at best, on no more than a glimpse of a narrative—enough perhaps to give us hope this is a narrative which exists and not a chaos."

It gets pretty chaotic soon enough, however. For instance, Mailer suggests that the real purpose of the Watergate break-in was to drive a nail into the ceiling of the Democratic National Committee's office: "A listening device is then attached to the nail." And the office above? It was occupied by "no less than the office of the secretary of the Federal Reserve Board . . . . The possibility is now open that the CIA was using the break-in to the Democratic National Committee as its elegant cover to the real operation, which was to tap privileged Federal Reserve Board information." Mailer suggests that this "inside information" was then being used to make "secret investments for the agency . . . . which soon brought huge profits . . . . these secret investments could total by now anywhere from $25 *billion* to $100 *billion* . . . . " (My emphasis.)

Then something else catches Norman Mailer's eye—"a list of the offices in July 1973, on the seventh and eighth floors of the Watergate building"; and he suggests, using a mode of thought that is pure, undiluted Jim Garrison, that we "take the pleasure of wondering how many of those names and corporations have no relation to intelligence." And what do we find when we look at the list? Oh-ho! "Defense and Aerospace Center of Sterling Institute, Inc. . . . Inst. for Psychiatry & Foreign Affairs . . . . R. F. Communications, Inc. . . . " *Very* suspicious, don't you see.

Next, Mailer suggests that because James McCord's lawyer, Bernard Fensterwald, had been chairman of something called the Committee to Investigate Assassinations (get the acronym?), an "enclave" within the CIA was trying to drop the hint that "Watergate is related to Dallas," which would be "the scoop of the century." A propos Dallas, Mailer says that there were "a hundred or more murders in Dallas supposedly connected to witnesses of the assassina-

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tion . . . to keep the seepage of information under control." Funny that only Mailer seems to know about those hundred murders.

Then there was the United Airlines crash, of course, the one that killed Dorothy Hunt and others. Mailer says: "An investigator, Sherman Skolnick, in Chicago, would lay the claim that twelve people in one way or another connected with Watergate were on the plane . . . . " What Mailer does not tell us, although by now we would certainly expect it, is that Skolnick himself is an arch-conspiratorialist whose credo is: "If we don't act weird, nobody will pay attention." The aforementioned Fensterwald has said of him: "Skolnick is just a plain wrecker." *The Washington Post* checked out Skolnick's claim and concluded that it had no substance and that he was nuts.

More Connections

Mailer seems to have become rather nutty, too, just like most of the other conspiratorialists on whose work he relies heavily in this piece. He concludes, "It is just that like Agatha Christie's characters, we all seem to end up knowing one another." And one immediately begins to wonder, what are *Mailer*'s connections in all of this? Wasn't there some way he could have linked himself into the pattern, too? How strange, that of all his writings in recent years, in which he invariably and portentously introduces himself as a character—Aquarius, Mailer, the Prisoner, Norman—there is this time no narrator in the foreground. And yet, wasn't there something one had read in the papers a few years ago . . . . ?

. . . Yes, that was it, the Four Seasons in New York, in 1973, when Mailer had celebrated his 50th birthday. His third wife, Lady Jean Simpson, and a publicity agent named Frank Crowther had suggested to Mailer when they were at the literary watering-hole Elaine's one day that he give a big public party. "Another ego trip? Who needs it?" Mailer replied. But then he changed his mind. Perhaps he could use the party as a launching pad for this new idea he had been cooking up. So Crowther sent out 5,000 invitations to the celebrities of politics, media, and lit. The invitation card promised that Mailer would make an announcement of "national importance (major)."

He was astute enough to keep the secret to himself until the last minute. "One thing New Yorkers can't bear is a secret they can't fathom," he said. So over 500 came—not bad considering it was $50 a couple, or $30 a head, and, as Sally Quinn would say the next day in *The Washington Post*, "Nobody who's anybody in New York ever pays to go to a party . . . . Monday night *everybody* paid. Even his ex-wives paid." And so they came: Shirley MacLaine, Andy Warhol, Jules Feiffer, Jose Torres, Jacob Javits, Marion Javits, Murray Kempton, Paul O'Dwyer, Bernardo Bertolucci, Lily Tomlin, Larry King, Larry McMurtry, Diane von Furstenburg, Dorothy Schiff, Ethel Scull, Eugene McCarthy, Elaine Kauffman, Huntington Hartford, George Plimpton, Arthur Schlesinger, Jr., Jack Newfield, Earl Wilson, Leonard Lyons . . . .

Then, after an introduction by Jimmy Breslin, Mailer stood up to the microphone to make his speech. He started out by explaining that he was not there "to start one more little movement to protect the press. Is there anybody here who has not been hurt by the press, except the press?" he asked. He had had this great new idea, the best of his life, which was to start a tax-free foundation called the Fifth Estate. It would be a "democratic secret police. A people's FBI and a people's CIA to investigate those two . . . . to keep tabs on the Washington secret police, which is not democratic but bureaucratic." On hearing this the crowd began to murmur, but Mailer went on talking and above the murmuring you could hear the words "totalitarianism . . . plots . . . Kennedy assassination . . . J.

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Edgar Hoover . . . the Eagleton thing . . . bugging."

Some people started to leave. "Will my agents get the names of people leaving?" Mailer responded anxiously. "Won't somebody ask a heartfelt question? . . . A hostile question? . . . We must see how far our paranoia is justified. . . . "

The next day Mailer called a press conference and admitted that although the party had been fine, his speech hadn't been very effective because he had been "a hint too drunk." And he apologized for using the phrase "secret police." "What I'm proposing literally is that we face up to the possibility that this country may be sliding toward totalitarianism . . . . We live in a land riddled with moral absurdity. I propose we start something equivalent to Nader's Raiders or the American Civil Liberties Union."

More Celebs

Five months later the celebs were back again, this time in Jimmy's Restaurant in New York, and by this time there had been a wonderful development. The Nixon "Enemies List" had been made public, and so the occasion was "An Evening With the Enemies"—$30 admission this time, proceeds to go to the Reporters' Committee for Freedom of the Press. Frank Crowther organized once again. And he reminded all concerned: "Remember how everyone said Norman was paranoid about the government? Well, Norman wasn't paranoid."

Norman was on hand for the party, even though by some strange oversight he had been left off the Enemies List. "It was a class B list anyway," said Dick Aurelio, a former aide to John Lindsay, who had also been left off. "And Jesus, where's Carter Burden?" asked Frank Crowther. "He's usually an automatic." But to liven things up Nixon made a TV speech that very night, and of course they brought a TV into the restaurant and had it on during the party, to the accompaniment of hooting, cheering, and derisive laughter. (This was during the Watergate "crisis"—remember?)

The party could be divided into two groups, Judy Bachrach noted in the *Post*. Those who weren't on the Enemies List, and those who were. "The real enemies who appeared formed an elite corps," Bachrach wrote, "and tended to associate mostly with each other. In one corner of the room civil rights leader Bayard Rustin was telling philanthropist Stewart Mott that he liked him even though he was rich." When Mailer was asked how he felt about the Enemies List he could only reply: "The only thing that Nixon and I agree upon is that Max Lerner should be on the Enemies List. That was a fine idea."

Meanwhile, despite the ridicule it had received after Mailer's speech, the Fifth Estate non-profit corporation got off the ground, and under its auspices a quarterly magazine began to appear—called *Counter-Spy*. Crisis Chic continued apace. In October 1973, Mailer appeared in public once again, this time speaking to the Women's National Democratic Club in Washington, where he attacked the press again, calling himself "the second most outraged man in America by the press," (Nixon, strangely enough, being number one), even though the press kept on dutifully reporting Mailer's antics, and kept on being invited to attend further displays. "One thing is crucial," Mailer told the Women's Club, "I must get the American people to love me."

Washington's Cleveland Park was the next crisis venue. "Saturday night Mailer spoke to about 100 guests at a Cleveland Park fundraiser for the Fifth Estate," the *Post* reported in March 1974, "which has four full-time employees—three of them former government agents. Many of the guests, mostly elegantly dressed, articulate antiwar activists, had come not knowing quite what to expect, but with the thought that, as one woman put it, 'wine, cheese and Norman

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Mailer were probably worth $10 a head.' " Mailer spoke once again, now claiming that his organization was designed to check "technofascism" and the "Big Brother state."

He added: "One night, the vision of an angel came to me in my sleep and said, 'You are the dolphin, you must ride forth and save France (the angel, being drunk, then said, I mean America).' I said, 'Anything to relieve me of my inimitable boredom.' "

The fun and games went on in this vein for another year or so, but then, late in 1975, there was an unexpected development, and thereafter anti-Americanism became noticeably less fashionable at the trendy watering holes and the smart dinner parties: Richard Welch, the CIA station chief in Athens, was murdered by gunmen as he left his house. Welch had already been identified twice in *Counter-Spy* as a CIA agent.

Technofascism Reeling

Well! A blow had been struck against technofascism, perhaps. Big Brother, at least symbolically, had been repudiated; Mailer could perhaps justifiably feel that his organization was beginning to achieve results. After all, the gunmen have not been caught. We do not know that they did not have a subscription to *Counter-Spy*, or that someone was not mailing a copy or two to Athens. Of course, it's also possible that the assassins learned about Welch from the State Department's own publications; or they might have known, as many people in Athens did, that the house Welch lived in had long been the residence of the CIA station chief—but no matter. The Welch-*Counter-Spy* link makes for better speculation. Even Mailer himself, dedicated discoverer of links and connections that he is, might have realized that the link between himself and Richard Welch was at least as plausible as the link-ups he tried to make in his *New York* article.

So one read on with curiosity: what was Mailer going to have to say about the Fifth Estate? Not one word, as it turns out. He seems to have missed that link! Mailer merely proclaims that we do not really know anything about the CIA, and through some strange mental contortion he is able to believe that this lack of knowledge constitutes positive evidence on behalf of whatever malign speculation happens to cross his mind on the subject.

It has frequently been said that one of Mailer's great strengths as a writer was his way with a metaphor. Funny then, that he has not noticed what I believe to be the case, that the CIA has now become a metaphor for his own peculiar befuddlement. Consider the following quotations, excerpted from his article, and let the idea float across one's mind that when Mailer says CIA, maybe he means himself:

"We have come to a circular place. The CIA occupies that region in the modern mind where every truth is obliged to live in its denial; facts are wiped out by artifacts; proof enters the logic of counterproof and we are in a dream . . . . We do not know if the people who make our history are more intelligent than we think, or whether stupidity rules the processes of thought at its highest level . . . . A man may work in the CIA for 20 years and never perform the role his title suggests he is performing. Two men may work side by side in the same office for ten years and never learn the other's real work . . . . a man's wife may only guess at his real activities . . . . After years of such work, one may no longer be certain of one's own function, loyalty or sanity—one can hardly be certain of the identity of one's friends, and one can never be sure the CIA has or has not made a new piece of history."

When Mailer says that a CIA man may not be certain of the identity of his friends, one thinks, especially, of Mailer at the Four Seasons, with his invited guests jeering and drifting out (his friends?) and his appeal for someone at least to ask a heartfelt ques-

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tion; and one thinks of him at the women's club: "One thing is crucial, I must get the American people to love me."

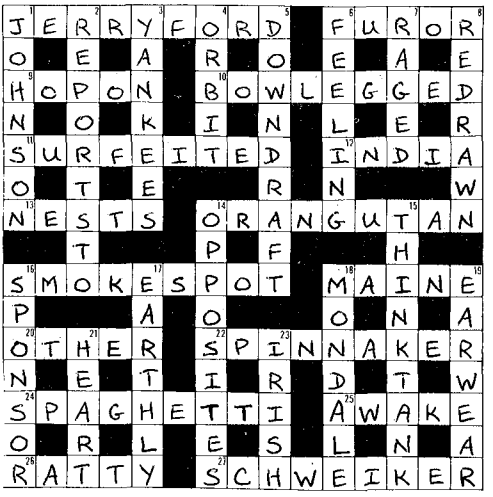
Confusion Triumphant

Mailer at some point in recent years took those fatal steps and crossed into the celebrity camp, putting on all the while this great act as Celebrity-Writer-Champ. It is so much easier, after all, to do this than to go through the hard work of writing something worthwhile; in fact, since his best writing is grounded in experience and familiarity, going the celebrity route makes it very hard indeed for him to write about anything at all besides celebrities. And, oh, the dread insecurities of celebrity! Do they really love me, like me, even? Is it *me* they like, or my fame? Am I really good? Can one ever know for sure? Can one know *anything* for sure? Confusion confusion. One can hardly be certain . . . Have another drink. (Hi, Norman, Hi, Andy. Hi, Norman, Hi, Elaine . . .) There are no longer, in this diaphanous world, any certainties—about oneself, obviously, but really about anything else either. The world works in mysterious ways. Who knows for sure *who* killed Kennedy? *They* did, of course. Things are not as they seem, that much one knows for sure. The CIA is involved somehow, but which wing? Which enclave? One does not know. One is busy with a million things, and cannot find out. Mailer is best writing about what he knows, but he doesn't know anything about the CIA. His article, like his world, has little grounding in reality, little room for certainty. There are no answers, only questions . . . .

In the end, Mailer sees, it is all America's fault. "What a crazy country we inhabit," he ends his article. "What a harlot. What a brute. She squashes sausage out of the minds of novelists on their hotfooted way to a real good plot." And there's some truth here, of course. In America, the fame and fortune that can come a writer's way are so potentially great that they can indeed squash him. It has happened time and time again. Mailer has at least insulated himself against the "fortune" side of the problem—large alimony payments having at least kept him writing, as he has conceded. But stardom he has actively sought, no doubt with disastrous results. And he is in a way right—it is the American problem as regards the arts. Especially in those arts that are performed with a high degree of spontaneity, such as music, wide popular acclaim has in almost every single recorded case resulted in the artist being frozen in his state of development at the moment of exposure, and then going into a swift decline. The peculiarly American problem is that the first work is so often the best (unless it went unrecognized). And this seems to have been Mailer's problem. Like a good boxer, though, he picked himself up 20 years after *The Naked and the Dead* and turned out an excellent book, *The Armies of the Night*, but since then he became one of the People Are Talking About People, and it has been downhill all the way.

So it wasn't the CIA, Norman, you did it to yourself. But you're probably right that it could only happen in America. ■

Answer to the September puzzle:



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political book notes

Public affairs books to be published in October

Among Those Present: A Reporter's View of Twenty-five Years in Washington. Nancy Dickerson. Random House, $8.95.

An American Company: The Tragedy of United Fruit. Thomas P. McCann. Crown, $8.95. The story of United Fruit is a fascinating one, and it touches on quite a few important themes in American business: entrepreneurship, the rise of management, corporate imperialism, the growth of public relations, and 60s stock manipulations and takeovers. It could, in fact, make a great book—but this isn't it. McCann, a former United Fruit vice-president, has written more of an autobiography than a history; there's very little research, and the whole account is disjointed and geared toward making McCann and his friends in the company sound good and their opponents evil. What is most interesting is what barely filters through, like the way United Fruit virtually ran parts of Central America for a time.

The Arabs, Israelis, and Kissinger: A Secret History of American Diplomacy in the Middle East. Edward R.F. Sheehan. Reader's Digest, $8.95. Inside information, well-written and put together, on Kissinger's shuttle diplomacy in the Mideast. This is an expansion of Sheehan's earlier article in *Foreign Policy*, which caused a tremendous fuss because it was full of unauthorized leaks and so forth—but it now turns out Sheehan got his material from a State Department official who thought it would be okay to release it. No doubt other such leaks go on all the time, and no doubt the regular Kissinger press corps is, alas, much better at self-censorship than Sheehan is.

The Assassination Chain. Sybil Leek, Bert R. Sugar. Corwin, $9.95.

Beyond the Presidency: The Residues of Power. Marie B. Hecht. Macmillan, $12.95.

Capitalism Can Survive in a No-Growth Economy. Herbert N. Woodward. Brookdale/Walker, $7.95.

The Challenge of the American Revolution. Edmund S. Morgan. Norton, $10.95. An important book by the author of *American Slavery, American Freedom.* He concludes, "The Founding Fathers of those days deserve the esteem that has been heaped upon them. They had the imagination to think that things need not be the way they were, and they had the nerve to act as their imaginations directed . . . . If we are to celebrate their achievement . . . it should be, I suggest, by continuing to think things need not be the way they are."

City Lives. James Wagenvoord. Holt, Rinehart & Winston, $12.95/7.95.

Cleaning Up America: An Insider's View of the Environmental Protection Agency. John R. Quarles, Jr. Houghton Mifflin, $8.95. The former deputy administrator of the Environmental Protection Agency says he wrote this book in airports and hotel rooms, and it shows it. It's an interesting and honest book,

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but hastily done and imprisoned by events to the exclusion of any real analysis.

Color Me Flo: My Hard Life and Good Times. Flo Kennedy. Prentice-Hall, $7.95/4.95.

Communication and Cultural Domination. Herbert I. Schiller. International Arts and Sciences Press, $7.95.

Democratic Promise: The Populist Movement in America. Lawrence Goodwyn. Oxford, $19.50.

Developing the ICBM: A Study in Bureaucratic Politics. Edmund Beard. Columbia, $15.

The Dynamics of Detente. Arthur Macy Cox. Norton, $8.95.

The Eccentric Tradition: American Diplomacy in the Far East. Robert A. Hart. Scribners.

The Economy: Old Myths and New Realities. Walter W. Heller. Norton, $8.95/$2.95.

Federal Port Policy in the United States. Henry S. Marcus, et al. MIT, $17.50.

For the Good of the Company. Isadore Barmash. Grosset & Dunlap. A fascinating, though not very well written, history of an actual company, the McCrory Corporation, and of the personalities and economic forces, large and small, that have shaped it. The author is a member of the business and financial news staff of *The New York Times*.

Freedom Spent. Richard Harris. Little, Brown, $12.95.

Friends and Lovers. Robert Brain. Basic Books, $10.95.

The Greatest Battle. Ronald J. Glasser, MD. Random House. An excerpt appears in this issue of *The Washington Monthly*.

The Healers: The Rise of the Medical Establishment. John Duffy. McGraw-Hill, $12.50.

The Health Robbers. Stephen Barrett, M.D., Gilda Knight, eds. Geo. F. Stickley Co., $10.50.

Henry Wallace, Harry Truman, and the Cold War. Richard J. Walton. Viking, $12.95.

I'm Radcliffe! Fly Me! The Seven Sisters and the Failure of Women's Education. Liva Baker. Macmillan, $9.95.

John Stuart Mill and Representative Government. Dennis F. Thompson. Princeton, $13.50.

A new plea for Appalachia
by the author of the classic
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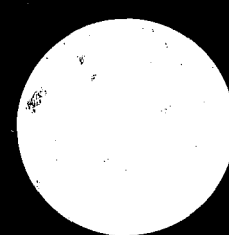

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Karen Ann Quinlan: Dying in the Age of Eternal Life. B.D. Colen. Nash, $7.95.

Kissinger: The European Mind in American Policy. Bruce Mazlish. Basic, $10.95. Our preeminent psycho-biographer takes on the Secretary of State, with mixed results. There is much earnest wringing of all possible meaning out of every scrap of evidence, but the record is fairly familiar to begin with. A good many of the psychoanalytic insights are just dressed-up common sense. Mazlish's tentative stabs at grand points about America don't come together well. Still, it's an interesting book, and its chief idea—that the key to Kissinger is his foreign birth and subsequent Americanization—makes sense.

The Long Tunnel: A Coal Miner's Journal. Meade Arble. Atheneum, $8.95.

Mafioso: A History of the Mafia from Its Origins to the Present Day. Gaia Servadio. Stein & Day, $10.

Men, Money and Magic. Jeffrey Potter. Coward, McCann & Geoghegan, $9.95. This biography of Dorothy Schiff, the publisher of the New York *Post*, is tasteless, sycophantic, and totally absorbing. Whatever her faults and whatever the author's limitations, Dorothy Schiff has been involved with some of the more interesting people and events of our time.

The Making of an Assassin: The Life of James Earl Ray. George McMillan. Little, Brown, $8.95.

The New American Dream Machine. Robert L. Sansom. Anchor, $8.95. Sansom, a former official in the Environmental Protection Agency, says the age of industry as the environment's chief enemy is over; industrial pollution is coming under control. The problem for the next 25 years, Sansom says, is "lifestyle pollution," things like too many cars and suburbs, so that what we all need is to live a little more simply and to grow a little less quickly. Given that, in the year 2000 will begin an era of pollution-free growth, a sort of golden age, says Sansom. An interesting book, and, by the way, the kind that creates a powerful impression that its author wouldn't refuse a call back into the government from some high-ranking reader.

New Lives: Survivors of the Holocaust Living in America. Dorothy Rabinowitz. Knopf, $8.95.

Nimitz. E.B. Potter. Naval Institute, $16.95.

Nobody Speaks for Me! Nancy Seifer. Simon & Schuster, $10.95.

Norman Thomas: The Last Idealist. W.A. Swanberg. Scribner's, $15. Swanberg, previously notable as the biographer of press lords (Luce, Hearst, Pulitzer), here turns his attention to the perennial Socialist Party presidential candidate and fighter for unpopular causes. This book is written a lot like Swanberg's other biographies, in exhaustive narrative detail without excessive probing or analysis. What deeper insight comes out, and indeed quite a bit does, comes out on its own, with no pushing by Swanberg. Because of Thomas' endless career and wide associations, his biography is a tour of the Old Left, through myriad crises and factions, for most of this century. Thomas himself was rather atypical—always genteel and kind, not given to internecine warfare, staunchly anti-communist and pro-civil liberties, and strangest of all, happily resident in a Long Island estate and always treated kindly by people in power.

Nuclear Power: The Unviable Option—A Critical Look at Our Energy Alternatives. John J. Berger. Ramparts Press.

Of Woman Born—Motherhood As Experience and Institution. Adrienne Rich. Norton, $8.95. There's no escaping the comparison of this book to Susan Brownmiller's *Rape*: both are heavily researched historical/sociological examinations of institutions through which women have been, the authors hope to prove, exploited through the ages. Rich, a National Book Award-winning poet, has chosen a far less fat target than Brownmiller did, for while everybody agrees rape is bad, the case against motherhood (it "must be destroyed," Rich writes) is less open-and-shut.

Well, it turns out Rich isn't against motherhood per se, but rather against the way men have used it as a way of keeping women away from the world's business, their creativity stifled and their feelings of guilt and inferiority exacerbated. There are passages, in fact, extolling the joys of motherhood and refuting the most extreme feminist theorists on the subject. For what she *does* want to say about motherhood, too, Rich has marshalled a great deal of evidence impressively. It is clear that motherhood as traditionally perceived has been used to do bad things to women.

At the same time, Rich carries with her

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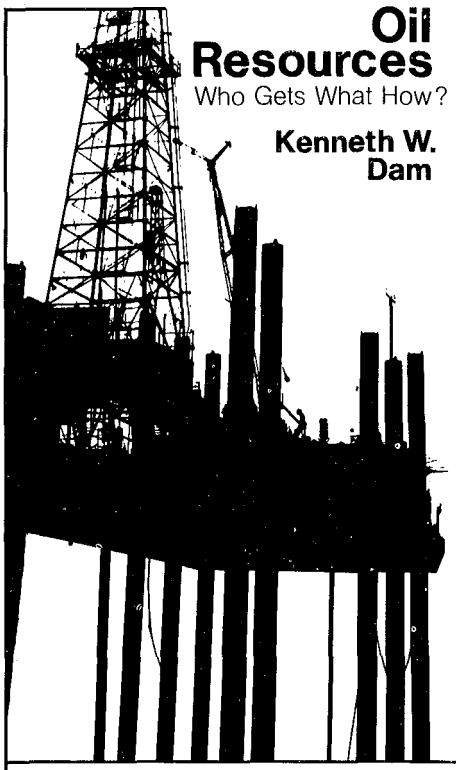

Oil Resources

Who Gets What How?

Kenneth W. Dam

This timely book on a subject of growing international importance is written by a highly qualified man—an expert in economic law who has been assistant director of the Office of Management and Budget and executive director of the Council on Economic Policy. Dam uses the experiences of Britain and Norway to illustrate the problems in the allocation and licensing of goverment-owned resources. He compares the discretionary and auction systems of allocation and makes a strong case for the economic efficiency of the latter which is the system practiced regularly only in the United States. Dam's conclusions are applicable to the development of other scarce resources and are therefore of the greatest value to all interested in public policy.
$11.95

The University of Chicago PRESS

The Powerholders

David Kipnis

As Kipnis points out, there have been many studies of those who are the targets of power but too few of those who wield it. From a psychologist's viewpoint, he considers the nature of power and its uses not only by presidents, corporate executives, military leaders, union officials and other professional powerholders but by husbands, wives, and parents. One of his main aims is to determine what changes take place in the values of powerholders when impulses that were originally humane are replaced by selfish and egoistic ones.
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much of the unfortunate excess baggage of the women's movement. The movement's, and Rich's, great sensible point is that men have consistently failed to understand women and have as a result been cruel to them; but having seen this, Rich falls into the same pitfall as regards men, and portrays them with little understanding. This is a radical book, and it sees things in extremes. Its women, more often than not, are in the most unusually degraded position women can be in; its men are as evil as men can possibly be; and the happy nuclear family is, in Rich's world, simply nonexistent.

If all this seems to contradict the broad range of experience, well, remember, this is a book whose aim is to push outwards the frontiers of our thoughts. One does not accomplish that by dwelling on what is good in the present system, and if by that omission some balance is lost, it seems to have been cast aside on purpose.

Organizing the Presidency. Stephen Hess. Brookings, $10.95. The author, who was Pat Moynihan's deputy in the early days of the Nixon presidency, has written a thoughtful book recommending that the President stop trying to manage everything and give more emphasis to "a relatively small number of highly significant political decisions—among them, setting national priorities, which he does through the budget and his legislative proposals, and devising policy to ensure the security of the country, with special attention to those situations that could involve the nation in war."

Our Blood: Prophecies and Discourses on Sexual Politics. Andrea Dworkin. Harper and Row, $7.95.

Paul Robeson—All American. Dorothy Butler Gilliam. New Republic, $8.95.

Roger Baldwin, Founder of the American Civil Liberties Union. Peggy Lamson. Houghton Mifflin, $12.50.

Portrait of a Cold Warrior. Joseph Burkholder Smith. Putnam, $11.95.

Pro-longevity. Albert Rosenfeld. Knopf, $8.95.

Public Persons. Walter Lippmann, Gilbert A. Harrison, ed. Liveright, $7.95. A collection of nearly 60 years of Lippmann's short writings on various famous people, skillfully and honestly edited by the former editor of *The New Republic*. Perhaps this book will help to demystify Lippmann, who is now one of the great uncriticizable figures of the century. For all his good qualities, Lippmann was a near-perfect embodiment of the unattractive aspects of the liberal Progressive tradition; his considerable elitism shines through on every page, and people should remember that he was a man who believed that "the main difficulty in democratic society arises out of the increasing practice of liberty."

RIO: Reshaping the International Order, A Report to the Club of Rome. Jan Tinbergen, ed. Dutton, $10/4.95.

The Phone Book: What the Telephone Company Would Rather You Not Know. J. Edward Hyde. Regnery, $7.95.

Roosevelt and Churchill—1939-1941. Joseph P. Lash. Norton, $12.95. This book seems to be based entirely on documentary sources except for a prologue that tells of the author's one meeting with Churchill. Thus it is not infused with the kind of personal understanding that the author's friendship with Mrs. Roosevelt made possible in *Eleanor and Franklin*. Still it tells a great story—the sub-title "The Partnership That Saved the West" seems quite accurate—and is a valuable reminder that there was a time when we needed a strong president.

Running for President. Martin Schram. Pocket Books, $1.50. Excellent reporting of Carter's campaign for the Democratic nomination by the Washington bureau chief of *Newsday*.

A Sailor's Admiral: A Biography of William F. Halsey. James M. Merrill. Crowell, $9.95.

To Have or To Be? Erich Fromm. Harper & Row, $6.95.

Vietnam: The Unforgettable Tragedy. Joseph Buttinger. Horizon, $8.95.

The Virgin Diplomats. Elmer Bendiner. Knopf, $10. An amusing account of the adventures of our first ambassadors to the courts of Europe.

Volunteers, One and All. Bruce Bliven, Jr. Reader's Digest, $7.95.

The War Lords: Military Commanders of the Twentieth Century. Field Marshal Sir Michael Carver, ed. Little, Brown, $17.95.

Why Is There No Socialism in the United States? Werner Sombart. International Arts and Sciences Press, $17.50.

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Jet Economics

Inflation has caused the cost of goods and services to rise as if they were jet propelled. But, ironically, the average airline fare has climbed very little and very slowly, indeed.

In 1975, the Cost of Living Index for all U.S. products and services rose by 9.1%. The average domestic airline fare per mile went up only 2.1%.

Through June, 1976, the Cost of Living Index has gone up an additional 6.2% and the average airline fare about 2%.

Time savings aside, with discount fares, air travel today is frequently less expensive than the cost of car, bus or train travel.

Increase in Airline Fares Vs. Other Goods & Services 1948 to 1976.

Newspapers **242%**
Bus Fares (Intercity—Class 1) **174%**
Gasoline **143%**
Men's Shoes **139%**
Food **129%**
Electricity **89%**
Hospital Semi-Private Room **774%**
All Goods and Services **124%**
Air Fares (U.S. Scheduled Airlines) **20%**

(Source: Bureau of Labor Statistics, Civil Aeronautics Board, National Association of Motor Bus Owners)

How do U.S. air fares stack up against those in other parts of the world?

Lower.

Here are some examples:

U.S. Fares

Washington-Detroit
404 Miles, $54

Atlanta-Boston
946 Miles, $95

Chicago-Los Angeles
1,745 Miles, $153

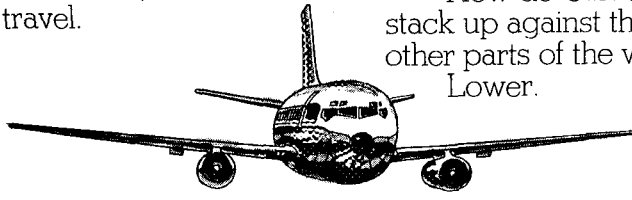
Foreign Fares

Paris-Milan
395 Miles, $96

Rome-Copenhagen
955 Miles, $221

Bombay-Tehran
1,741 Miles, $254

Looking to the future, it may be necessary to adjust air fares to keep up with rising costs (jet fuel, for instance, rose 20% last year—127% since 1973). But airline ticket prices will continue to receive good marks.



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